NURSING TIMES

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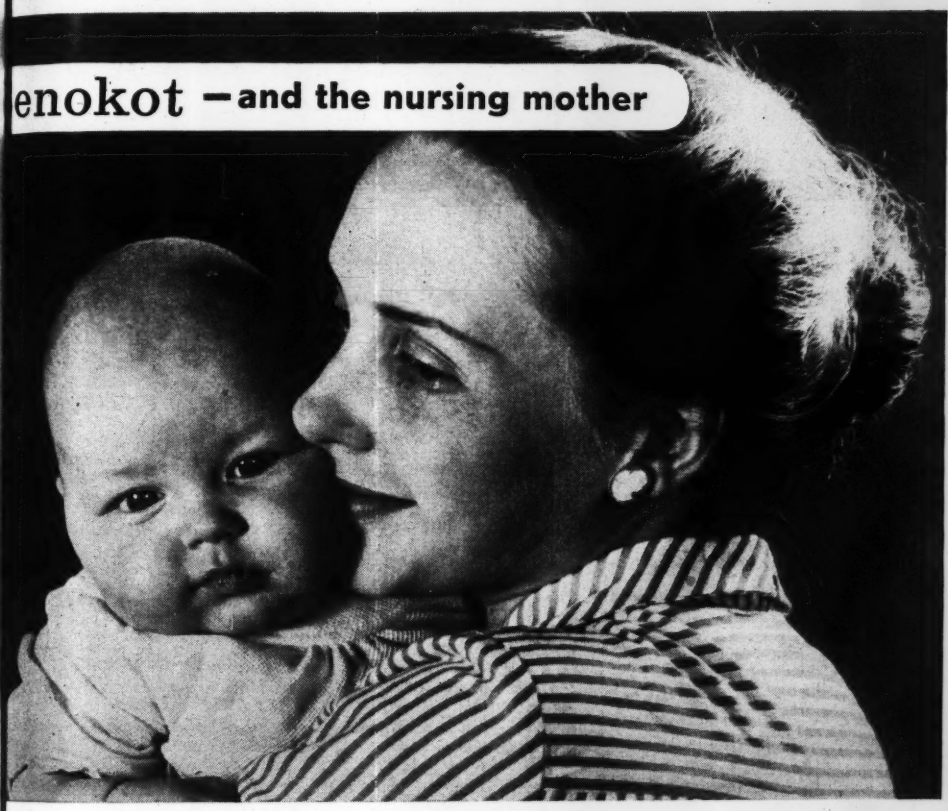

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College Council Meeting, January

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Prevention of Scale Formation in Hot Water Sterilizers

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Royal College of Nursing News

6D
Weekly

Journal of the Royal College of Nursing

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RIDAY, JANUARY 23, 1959

Official Journal of the Royal College of Nursing

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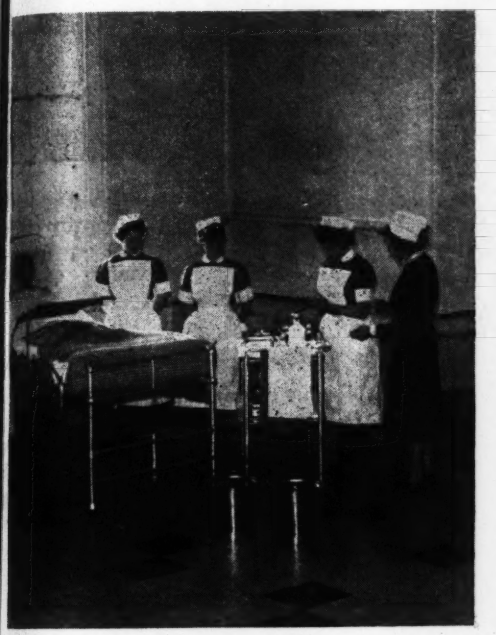
NURSING TIMES



Student nurses receiving practical instruction in aseptic techniques in the new PTS at Dudley Road Hospital, Birmingham (*see also page 95*).

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Cross Infection

IT IS IMPERATIVE that exacting care in carrying out techniques must be the rule in every hospital if infection is not to be transmitted from one patient to another.

A profession in its widest sense implies service to the community as a whole; but to provide a good service there must be technical competence, expert knowledge and proper practice. For this reason we are devoting considerable space in this issue to an abstract of the report on Staphylococcal Infections in Hospitals*, by a sub-committee of the Standing Medical Advisory Committee of the Central Health Services Council, which is published this week.

We make no apology for occupying so much space in the *Nursing Times* with this matter, for it is of vital importance if the health of the nation is to be protected. Furthermore, we consider that nurses should, as part of their professional duties, devote time to reading such material, and to considering how they may implement, as far as they are able in their own work, the recommendations of these reports, especially when, as in the present report, another duty is recommended for the ward sister.

Some items of elaborate and expensive equipment such as autoclaves are not strictly speaking the responsibility of the nurse; but there are many matters, such as the proper techniques of aseptic dressings, which are her immediate concern. If nurses are dissatisfied in their own minds with the efficiency of certain procedures, it is up to them to bring them to the attention of the matron, who will take up the matter with other members of the hospital staff or the authorities.

The Nuffield research team, investigating sterilizing practice, noted that sterile equipment was not being properly stored owing to faulty or improvised lids of containers, but, the report states, "the nursing staff excused these faults by saying that it was difficult to obtain new lids". Dressing drums secured by safety pins are obviously unsafe and this fact must surely be recognized by the most junior nurses; but are the authorities informed of faulty equipment that can only lead to faulty techniques that sooner or later will provide the cause of outbreak of infection in hospital wards?

Proper aseptic techniques involve a long chain of procedures and of people; this chain, like any other, is only as strong as its weakest link. The weak link may be in autoclaving practices, unsuitable or inadequate equipment, in the technique of the most junior nurse or the teaching of the most senior ward sister. As nurses it is part of our duty to see that the nursing links are forged strongly; this requires knowledge of the most modern practices by those of the profession concerned in teaching student nurses, those who carry out the work, and those responsible for knowing that these practices are constantly carried out accurately.

* *H.M. Stationery Office, 2s. 6d.*

News and Comment

School Health Service Jubilee

THE SCHOOL HEALTH SERVICE is 50 years old, and there have been remarkable changes in the health of children. They are taller, heavier, better clad, better shod and cleaner; increasing numbers of children are too fat. Many children still smoke cigarettes, despite propaganda against smoking; an inquiry in an Isle of Wight secondary modern school showed that a third of the boys and 15 per cent. of the girls still smoke. The incidence of dental decay has increased in recent years and 4 per cent. of the school population have verminous heads. The killing and crippling diseases of the turn of the century—tuberculosis, rickets and rheumatism—have been almost eliminated but accidents kill more children than disease, and road accidents are responsible for half the deaths. This report is not entirely reassuring and we have heard reports that smoking in children's hospitals provides quite a problem in some areas; this is not helped by the fact that parents often bring in cigarettes to the children at visiting time.

Nurses Memorial to King Edward VII

MISS M. J. MARRIOTT, O.B.E., who made the BBC radio appeal for this nurses memorial fund in November, formally opened the recently installed lift in the retired nurses home at Fonthill, Reigate, on Saturday, January 17. This lovely house in its large garden is the permanent home for 30 retired nurses in the care of Miss J. H. M. Carruth, S.R.N., superintendent. The mayor and mayoress of Reigate, Mr. A. C. Wood-Smith, hon. secretary to the Nurses Memorial Fund, and members of the committee and friends were among those who watched the inaugural journey made by Miss Marriott and Alderman Searle.

RETIRED NURSES HOME, FONTHILL, REIGATE

Miss Marriott cuts the red ribbon watched by Miss Carruth and the mayor before the lift makes its inaugural journey.

Edinburgh Royal Infirmary

MISS MARY H. CORDINER, S.R.N., R.F.N., S.C.M., S.T.DIP., has been appointed lady superintendent of nurses at Edinburgh Royal Infirmary and will take up her new post on May 1. She is at present matron of Bristol Royal Hospital and principal, United Bristol Hospitals School of Nursing. Miss Cordiner trained at the Western Infirmary, Glasgow, City Hospital, Aberdeen, and Maternity Hospital, Aberdeen; she took sister tutor training at the Battersea College of Technology and the certificate in Nursing Administration at the Royal College of Nursing. She became ward sister and night superintendent at Sheildhall Fever Hospital, Glasgow; ward sister and assistant tutor under the London County Council, and was subsequently principal sister tutor and deputy matron at Aberdeen Roy Infirmary. She is a member of the South-West Regional Hospital Board and chairman of the A Nurse Training Committee; also chairman of th local branch of the Association of Hospital Matrons.

Medical Services Revie

"A GREAT MANY PEOPLE, patients as well as doctor are relatively happy", said Sir Arthur Porritt, "bu everyone is not completely happy. It is that lack complete happiness that should be improved." Th Sergeant-Surgeon to the Queen was speaking at a pre conference to announce the formation of a medica committee to review "the provision of medical service to the public, and their organization, in the light of l years' experience of the National Health Service" an to make recommendations. The committee is compose of medical practitioners representing nine bodies, th six royal colleges, the Society of Medical Officers Health, the College of General Practitioners and th British Medical Association. One woman, Miss A. M Dickins (R.C.O.G.), is on the committee. Citizens ar invited to submit their views.

An International Los

INTERNATIONALLY, the nursing profession has sus tained a loss in the death at the age of 82 of Miss Mar M. Roberts, R.N., B.S., who was for 38 years edito of the *American Journal of Nursing*. She completed he nurse training in 1899; later took the B.S. degree an the Certificate in Administration of Nursing Schools o Teachers College, Columbia University. In the Firs World War she became chief nurse of the Army Nursing Corps; by the end of the war Miss Roberts had alread contributed 20 years of distinguished nursing work, an when appointed editor of the *American Journal of Nursing* she greatly widened its scope and influence. Through out her career she participated actively in internationa nursing organization. In 1950 she founded the Mar M. Roberts Fellowship to assist each year a qualifie professional nurse to prepare herself in the technica aspects of nursing journalism.

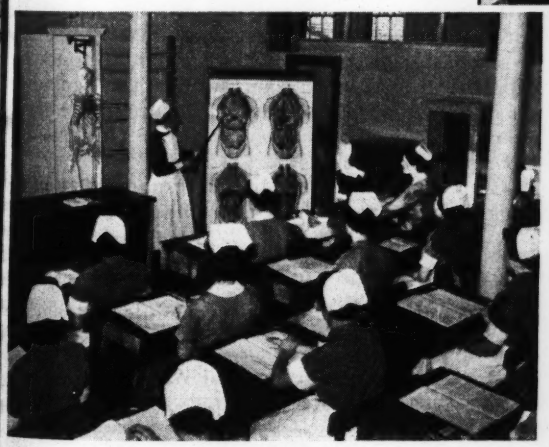
New School Building Dudley Road Hospital, Birmingham

◀ *The principal tutor and her assistants, (left to right) Miss E. Smith, Miss E. Starks and Miss H. Baugh, discussing nurse training plans in the spacious and comfortable office.*

▲ *The matron, the principal tutor, Miss N. M. Herbert, and a student nurse, admiring the plaque designed by Birmingham School of Art.*

The Olga Snowden Wing, named after a former matron of Dudley Road Hospital, was formally opened by Miss K. A. Raven, chief nursing officer of the Ministry of Health. There are five spacious classrooms and a kitchen. Nursing cadets, PTS students and student nurses all have their own teaching units and there is an annual intake of 24 students four times a year. Miss E. Clowes, the matron, expressed her pleasure that the school is an integral part of the hospital.

▲ *Clinical instruction in the classroom. A patient suffering from the effects of a head injury is brought to the classroom by the surgeon.*



▲ *First year student nurses studying anatomy under the guidance of Miss E. Smith, in the preliminary training school.*

▶ *In the new preliminary training school section, formerly the nurses quarters, now modernized and in parts rebuilt, the dietitian instructs two students on the various diet menus.*

CENTRAL HEALTH SERVICES COUNCIL
STANDING MEDICAL ADVISORY COMMITTEE

Staphylococcal Infections in Hospitals

THE OBJECTS OF THIS REPORT* are to draw attention to the prevalence of staphylococcal disease in hospitals, to discuss prevention, to summarize accepted control measures and to show problems that need further study. Two nurses, Miss B. Sidney, ward sister, St. Thomas' Hospital, London, and Miss Mary Williams, president, Royal College of Midwives, were co-opted on to the subcommittee whose main conclusions and recommendations are summarized here.

Members of the Special Sub-committee

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MISS B. SIDNEY, S.R.N.
MISS MARY WILLIAMS, S.R.N., S.C.M., M.T.D.
R. E. O. WILLIAMS, ESQ., B.SC., M.D.

Introduction

1. The control of staphylococcal disease depends largely on the application of aseptic methods. The use of antibiotics, either for treatment or for prophylaxis, is by itself unreliable.

Experience has shown that the continued use of any antibiotic in a hospital community is accompanied by the emergence of staphylococcal strains against which the drug is powerless.

2. Staphylococcal infection may give rise to disease in any department of a hospital, especially surgical and maternity units.

3. The extent of the problem may well be overlooked if there is no adequate system of recording or if facilities for bacteriological investigations are lacking.

Discovering and Recording Cases of Infection

4. Continual vigilance is needed to detect clinical signs of infection in patients and staff.

5. The progress of patients should be followed for long enough and with enough care to reveal any clinical evidence of infection.

6. The need for voluntary reporting of minor ailments, including septic lesions of the skin, should be impressed on all members of the hospital staff. This includes members of the medical, nursing, auxiliary and domestic staffs.

7. In all cases of suspected staphylococcal disease it is desirable to confirm the diagnosis by bacteriological investigations.

8. Records of clinical evidence of infection should be maintained in a simple, comprehensive and readily available form. (Table 2.)

9. The maintenance of a Control of Infection Register should normally be the responsibility of the nursing sister in charge of the ward or department concerned. To simplify current recording it may be helpful to the ward sister, in the course of her rounds, to mark the condition of the patient or the state of the wound by means of a symbol on the patient's temperature chart. These records must be examined by the clinician and are not an end in themselves.

10. Clinicians should accept the responsibility of examining their registers where their patients are treated.

Sources of Infection and Modes of Spread

12. The sources of staphylococcal infections are to

* *Ministry of Health* (*H.M. Stationery Office, 2s. 6d.*)

TABLE 2. Suggested layout of Control of Infection Register for use in Surgical Wards.

Hospital Reference No.	Patient's name	Date admitted	Surgeon in charge	Diagnosis	Date of operation	Evidence of infection	Date observed	Bacteriological investigations	Date discharged

be found in human tissues where staphylococci are multiplying, either in septic lesions or at healthy carrier sites. (Table 1.)

13. Transference of infection may take place directly from person to person either by contact or by airborne droplets, or indirectly by way of contaminated articles or airborne dust. The first step in indirect transference of staphylococci from their source is by contact to other persons or to objects such as bedclothes, towels or particles of dust.

14. Staphylococci are moderately resistant to drying and remain viable for considerable periods. Most of the inanimate objects in hospital may act as depots for these organisms. These objects include clothing, handkerchiefs, crockery and cutlery, thermometers, sputum containers, bedpans and urinals, sheets and blankets, pillows, mattresses, bedsteads, bed curtains, screens, examination couches, walls, floors, wash-basins, sluices and water closets. These objects may in turn pass their contamination on to other persons or objects.

Principles of Prevention

15. It is important to allow adequate space for the patients' beds and enough time for the staff to carry out preventive measures which are needed. In an open general ward the minimum distance between bed centres should be kept at 8 ft. Overcrowding of patients may militate against a satisfactory turnover by prolonging the stay of those who become infected or by the closure of wards as the result of outbreaks. The practice of 'lodging' patients temporarily in hospital wards in order to clear beds elsewhere in the hospital has obvious dangers and should be adopted only when circumstances make it essential and with adequate precautions.

16. The control of sources of infection may be hindered by the widespread or indiscriminate use of antibiotics. Clinicians should be prepared to consider certain voluntary restrictions in the use of these drugs. These may include keeping certain antibiotics (such as erythromycin) in reserve for the treatment of patients infected by organisms resistant to drugs more commonly used; to limit the authority to prescribe certain antibiotics and to abandon the widespread use of antibiotics for non-specific prophylaxis.

17. Patients should be protected from exposure to risks of infection. Members of the staff with staphylococcal infection should not remain on duty; patients with septic lesions should either be isolated in single rooms or segregated in special wards. Wounds should ideally be dressed in properly designed treatment rooms. If dressings must be done in open wards they are best done at times when there are few disturbances and no visitors. Cleaning of floors and drawing of bedside curtains should be completed at least 15 minutes before dressings begin. Infants' toilets should conform as far as possible to a wound dressing technique.

18. The dispersal of organisms from contaminated dressings, clothing, bedding and dust should be kept at a minimum. The clothing and bedding of an infected patient are second only to soiled dressings as a means of dispersal of organisms. It can be reduced by the treatment of blankets with suitable oil ('technical white oil' or Triton oil emulsion*) but regular sterilization (with Cetyl Trimethylamine Bromide†) is probably more satisfactory. Dust-laying oils to all floors have been recommended for wooden floors or linoleum (spindle oil*) and the alternative to oiling is minimal dispersal of dust by damp dusting, piped suction or the use of vacuum cleaners with efficient air filters.

Site of Infection	*Nature of Lesion*
*Skin	Furunculosis Impetigo Pemphigus neonatorum Other pustular eruptions
Breast	Abscess Cellulitis
*Umbilical stump	Suppuration
Wounds	Sepsis
Burns	Sepsis
Eye	Conjunctivitis Ophthalmia neonatorum
Ear	Otitis externa Otitis media
*Nose	Furunculosis
Respiratory tract	Sinusitis Pharyngitis Laryngitis Tracheitis Bronchitis Pneumonia Lung abscess
*Intestinal tract	Post-therapeutic diarrhoea
Genito-urinary tract	Urethritis Cystitis Pyelitis

**These are also common healthy carrier sites.*

Table 1—Common Sites of Staphylococcal Infection

The most important means of dispersal into the air by staphylococcal carriers among the staff is from the clothes or normal working uniform. This is not much reduced by wearing gowns over *contaminated* clothes; simplification of nurses' uniform so that clean garments can be worn every day and the use of washable aprons are matters for further investigation. In operating theatres and delivery rooms all persons should change their outer clothing and should wear special boots.

19. Wounds should ideally be dressed in properly designed treatment rooms.

20. Staff exposed to the risk of infection should be protected by wearing gloves, gowns and masks or other protective clothing.

21. Particular attention should be directed to the proper disposal of articles removed from a heavily contaminated area by sterilization, incineration or disinfection. Contaminated material should be placed in suitable containers and removed by a route that does not lead through places where sterile materials are exposed. Sterilization by heat is to be preferred to chemical disinfection. Glaring omissions have been shown in the disinfection of patients' blankets and

**M.R.C. Memorandum 11. Control of Cross Infection in Hospitals.*

†'*Nursing Times*', *February 21, 1958, p. 214.*

mattresses which commonly undergo no disinfection for prolonged periods of use. Blankets should be laundered at least with each change of occupant of a hospital bed or cot. Ward blankets should not be taken into the clean part of an operating theatre. Gradual replacement of woollen blankets by one of the alternatives (certain cotton or cotton and rayon fabrics, Turkish towelling or cellular cotton weave are said to be durable, warm and unaffected by laundering processes conducted at a temperature high enough to kill staphylococci).

22. The hazards of airborne contamination can be reduced by controlled ventilation.

23. Clean or sterile articles should be protected from contamination.

Practical Details of some Preventive Measures

24. Patients with septic lesions should preferably be isolated in single rooms.

25. Single rooms should be available for the isolation of members of the staff with septic lesions.

26. Ancillary rooms should be planned with due attention to the need for protecting clean or sterile materials from contamination.

27. Washing facilities should be available in all situations where they are likely to be needed.

28. Supplies of equipment needed for the maintenance of effective preventive measures must be adequate for the purpose.

28. Isolation nursing techniques should be employed in the treatment of patients with septic lesions.

30. Techniques which incorporate some of the principles of isolation nursing should be applied to the nursing of infants.

31. Operating theatre practices should be designed to reduce the risks of infection.

32. The use of gloves, masks and gowns is advocated in a variety of circumstances: masks for all isolation procedures, surgical operations, deliveries, wound dressings, nursing of premature babies, preparation of babies' feeds, performing spinal or thoracic puncture. Masks should be made either of six layers of muslin or of two layers with one impervious layer of paper or cellophane inserted. Expendable paper masks are now available. The evidence of the usefulness of masks in maternity nurseries is equivocal. Gowns should be worn for all the procedures mentioned under 'masks' and also in maternity nurseries. Gowns will protect the clothing of the attendant from contamination. Staff employed in cleaning baths, wash-basins, water closets and other contaminated articles should wear intact rubber gloves for the purpose.

33. All members of the staff in attendance on patients should wash their hands before or after each item of service. Washing does not sterilize the hands but it does effectively remove recent contamination from the skin. Further investigation is needed of the optimum length of time for hand-washing and of the value of disinfectant soaps or creams. It seems reasonable to prefer short periods of washing undertaken as an invariable routine to long 'scrubs'. It is recommended that surgeons should 'scrub up' for five minutes at the beginning of an operating list and wash again before each operation. In the wards the hands of the attendant should be washed before and after each item of service whether or not gloves have been worn. For the preparation of skin of patients before surgical operations a preliminary washing of soap and water may be followed, when the patient is on the operating table, by the application of a suitable skin antiseptic.

34. Blankets should be regularly disinfected.

35. Mattresses should be either regularly disinfected or protected from contamination by an impermeable cover.

36. The disposal of soiled, fouled or infected linen should conform to the recommendations of the CHSC's Committee on Hospital Laundry Arrangements (to be issued shortly).

37. Effective methods of disinfection or sterilization should be practised. (See Nuffield Report on Sterilization Practices and MRC Prevention of Cross Infection in Hospital, '51†.)

Control of Outbreaks

38. The control of outbreaks may call for a variety of additional methods of investigation and prevention.

Administrative Considerations

39. The hospital control of infection officer occupies a key position in the co-ordination of regular preventive measures and the control of outbreaks.

40. Other senior members of the hospital staff must also co-operate in the prevention of infection and training and supervision of those concerned.

41. The hospital control of infection committee should meet regularly to review the sepsis record.

42. The hospital management committee or board of governors should ensure that adequate arrangements are made to control hospital infection.

43. The board of governors of a teaching hospital may wish to consider the additional problems associated with the presence of medical students. Medical students should be required to conform to the standards expected of other members of the hospital staff.

44. Regional hospital boards should make themselves generally familiar with arrangements in their regions and ensure that liaison is maintained with central and local authorities who have an interest.

45. It is important to maintain adequate liaison both within the hospital and with relevant agencies outside it. Greater collaboration between hospitals, general practitioners and local authority services is highly desirable.

APPENDIX I

Rules for Isolation Nursing

The efficacy of isolation nursing in the prevention of hospital infections depends on:

(*a*) adequate accommodation

†*See 'Nursing Times', January 9, 1959, p. 34.*

(*b*) proper facilities for hand-washing and for the disposal of contaminated articles
(*c*) efficient ventilation
(*d*) strict observance of the rules by all members of the staff—nurses, doctors, students, physiotherapists and other ancillary workers.

Isolation nursing is likely to prove most effective where the patients concerned are accommodated in single rooms. On account of the risks from airborne infection it is likely to be less effective where the accommodation consists of cubicles or screened positions within a multi-bedded ward and least effective where there is no structural separation.

The following rules are intended to apply to patients isolated in single rooms or segregated in multi-bedded wards. The term 'isolated area' will be used to denote a single room or the space around the bed in an open ward.

1. *Windows* and ventilators should normally be kept open.

2. *Doors* should normally be kept closed.

3. *Articles* needed by the patient, or needed for the patient's treatment, should be kept, as far as practicable, within the isolated area. When dressings have to be done, the equipment will usually have to be taken from the general ward stock, but it is important that everything brought out of the isolated area should be disinfected, or sent for destruction, without delay. For this reason dressing trays, if the ward has a sterilizer large enough to deal with them, may be preferable to dressing trolleys. Destructible containers should be used for soiled dressings. Care should be taken in the disposal of urine and faeces. Urinals and bedpans should be disinfected without delay.

4. *Gowns* should be provided for each isolation bed and should be worn by the attendants at every examination or treatment of the patient. When not in use they should be hung on hooks within the isolated area. Clean gowns should be issued daily and the used ones laundered and sterilized.

5. *Masks* should be worn by all attendants on entering an isolated area and discarded on leaving.

6. *Attention to the patient.* Before entering the isolated area the attendant should bare the arms to the elbows and put on a clean mask. Immediately after entering the isolated area the attendant should put on one of the gowns kept there, then wash the hands in soap and water and dry them. After attending to the patient the attendant should remove the gown, hang it on the hook provided for it and again wash the hands. The mask should then be removed and discarded, care being taken to handle only the tapes.

7. *Patient's notes* and charts should be kept outside the isolated area.

8. *Cleaning.* A gown reserved for the use of the ward maid should be among those kept within the isolated area. Essential cleaning equipment should also be kept within the isolated area. Dusters should be damped with disinfectant solution before use and boiled after use. The floor should preferably be washed. The alternative to washing is damp-sweeping with a broom kept within the isolated area. (Oiled floors should be swept with dry brushes of medium hardness.)

9. *Terminal Disinfection.* After the patient's discharge all non-expendable articles within the isolated area, including the bed-linen, blankets, mattresses, pillows and cleaning equipment should be disinfected. The bed and other furniture, the floor and walls should be wiped with disinfectant solution and thoroughly cleansed.

APPENDIX 2

Rules for the Performance of Wound Dressings

The rules must be followed for both clean and infected wounds. When dressings are carried out in the ward, dusting, sweeping, bedmaking and unnecessary traffic should cease, and bed-curtains should be drawn, 15 minutes before wound dressings are begun. Only one wound should be uncovered at a time.

Dressings may be performed by one person working alone, or by a team of two persons (dresser and assistant). The latter has the advantage that the dressing trolley does not have to be set anew for each patient, although it ought to be reset after the dressing of a septic wound.

Rules for a single dresser

1. Wash the hands thoroughly and dry on a clean towel.
2. Prepare dressing trolley, either using pre-packed complete dressing kits or collecting into dishes the necessary sterile forceps, scissors, dressings and lotions from the stock drums, etc.
3. Proceed to the bedside. Adjust the patient and the bedclothes. Remove the outer dressings, but leave the innermost dressing in place. Soiled material should be placed directly into a container in which it can be taken for sterilization or destruction.
4. Wash and dry the hands.
5. Carry out the dressing, using a strict no-touch technique. It may be useful to have a sterile towel available to place on the bed as a resting place for material. Cover and bandage the wound.
6. Adjust the bedclothes.
7. Discard surplus clean material for re-sterilization. Place instruments and bowls in sterilizer. Mop trolley-top with disinfectant.
8. Wash and dry hands.

Rules for a two-person team

The team comprises a 'dresser' who takes off the bandages and dressings, and attends to the toilet of the wounds, and an 'assistant' whose sole duty is to look after the trolley and pass clean things to the dresser.

Dresser	*Assistant*
1. Wash and dry hands.	Wash and dry hands.
2. Arrange patient and bedclothing; take off and discard outer dressings.	Collect necessary material from dressing kit or drums, bottles, etc. Prepare moistened swabs as needed.
3. Wash and dry hands.	
4. Remove and discard inner dressing. Carry out wound toilet, using sterile forceps and strict no-touch technique.	Supply dresser with all sterile material, using long handled forceps (kept in disinfectant when not in use) which must never touch non-sterile material.
5. Discard forceps and any contaminated material for re-sterilization.	In the case of a dressing on a septic wound, discard any surplus clean material on trolley top for re-sterilization.
6. Wash and dry hands.	

Dressing rooms

Either of the two routines described may be used. In busy outpatient or casualty dressing rooms it may be possible for one trolley assistant to supply two dressers.

Letters to the Editor

The editor welcomes readers' letters, which should be addressed to her at *Nursing Times*, Macmillan and Co. Ltd., St. Martin's Street, London, W.C.2. (WHI 4757/8/9). Names and addresses need not be published but must be given.

MENTAL ILLNESS STIGMA?

MADAM.—I feel I must reply to S.R.N.'s letter on mental illness stigma in the *Nursing Times* of January 9. I do not for one moment doubt that the experiences of the nurses with histories of mental illness are neither isolated nor exaggerated.

However, there is a point of view in which the word *stigma* has no place, which is entirely ignored by S.R.N.

Let us not deceive ourselves about the truly remarkable cures some of the new treatments and drugs have achieved in mental illness, cures which are complete only temporarily, so far. There are no official statistics about the percentage of relapses in two, five or more years. But at several visits to mental hospitals I have always made a point of asking the medical superintendent about the question of relapse after modern treatment and have invariably received the reply that the percentage of relapses is high, more so with some complaints than with others, but certainly higher in people who return to work which carries a high degree of responsibility and tension.

I have worked as a health visitor for some years; at one place where I was employed, the medical officer accepted an H.V. back to work after she had received mental treatment as a voluntary patient and after she had proved herself completely stable working as an assistant in a flower shop for two years. She was only back at health visiting for 18 months before she had another breakdown, the beginning of which she was able to conceal so well that some very tragic things happened and the police, the local press, etc., were involved before the end. I have also in another area worked with an A.M.O. who had been given leave of absence for voluntary mental treatment, who was cured and kept perfectly all right while she was on leave, but as soon as she had to listen to and deal with other peoples' problems she just broke down again and had to be finally pensioned off.

It is in the interest of the patient's own mental health and not because of a stigma that they should not seek re-employment in the nursing field. To help others face problems which, if they happened to us ourselves, might easily prove too much for us, requires complete emotional detachment and that means extreme tension.

If a matron employed a nurse with a history of active T.B., though at the time of employment dormant and 'cured', in a medical ward, everybody would blame the matron, maybe even sue her, if the nurse's chest condition became active again and she were not discovered till she had infected someone else. Nurses with a history of T.B. infections who are sometimes employed in sanatoria are under the strictest medical supervision and they do not resent it as a stigma.

This is the answer to S.R.N.'s second question: if any member of a nursing team has a known history of mental illness she *must* have special supervision; if she calls that 'stigma' I would suggest that she is not realistic, but still feels persecuted.

Let her look at her former illness in a different light. If she had been cured of cancer or T.B. she would be pleased to have regular check-ups and to accept the fact that there are unfortunately certain jobs she cannot for her health's sake do. Why can S.R.N. not accept the fact that the matrons who refused to employ her really did so for her health's sake and because of their experience and judgement and not because of any personal attitude to the mentally ill.

HEALTH VISITOR.

Surrey.

WOMEN IN AUTHORITY

MADAM.—Recently an eminent psychiatrist gave me his views on Women in Authority. I drew a deep breath and looked for an orange box from which to s:age my defence; but I was brought up on C. P. Scott's maxim—'Comment is free but fact is sacred', so I could do no better than say "you cannot generalize, it is not a proven fact that women in authority are less good than men."

Thinking the subject over, and if the premise is true, then surely it is not because women as women are psychologically less well endowed for authority than men, but because in the first place they have less tradition of authority and, in the second place, women in authority are usually single women and this implies a social and economic disadvantage *vis-à-vis* their male counterparts.

Even with so-called equal pay women usually earn less than men for the same weight of responsibility. Furthermore, as Wrangler points out, the man would most probably be married and have a wife to run his household. Single women must either 'live in' and on top of their job often at the expense of any private life, or they must live out and come home at night to the kitchen sink, the dust and the horrible knowledge that they have forgotten to buy a loaf of bread. By the time they have done all the tasks that a man would expect to have performed for him it is nearly time for bed.

The social aspect is perhaps more important; unless the woman has a large and handy family her outside contacts tend to be other single women often engaged in the same occupation—it is all too easy to go on discussing the job, and of course reforming it, long after hours. If a man did this he would be heading for a divorce.

However there is no way of knowing whether the premise that women are bad in authority is true; it is only an opinion and until women in authority are accepted as naturally as men and on their merits it is a subject on which we are not likely to be very objective.

But I would like to add another proposal to Wrangler's suggestion that £3,000 per year should be the sum to compensate for living in and being on call all hours of the day and night: that single women should be allowed income tax relief for domestic help to the extent of having the domestic services performed for them that a man normally expects from wife or housekeeper. It seems quite logical to me, but so far I have failed to convince any Member of Parliament of the beautiful clarity of my logic.

M. E. BALY.

Bath.

(*More letters on page 115*)

SHORTER PLEASE! Letters often have to be held over for a week or two for lack of space—so could you make them as short as possible please?

CASE STUDY

Anthony—Hirschsprung's Disease

DAPHNE W. MATTHEWS, S.R.N., Staff Nurse, Royal United Hospital, Bath

ANTHONY WAS ADMITTED when he was five days old for investigations of vomiting and abdominal distension. A breech extraction, he was born with the cord around his neck; although limp he was not asphyxiated; he weighed 6¾ lb. From the second day the baby had been vomiting slight greenish fluid, thought to be liquor amnii. After three days' continual vomiting, abdominal distension became apparent and progressively worse until admission. Three meconium stools only were passed in his first five days, but he was passing urine normally.

Anthony was the sixth child in the family; all the others were healthy except one who had contracted polio some time earlier. The pregnancy had been normal and both parents were healthy.

Examination revealed gross abdominal distension with prominent abdominal veins. No peristalsis was noted. Girth of abdomen was 17 in., tympanic to percussion. No obvious tenderness, free fluid or masses felt. Baby slightly dehydrated.

Scalp—some overlapping of the skull bones with small fontanelles. Head circumference 13½ in. Heart, chest, ears, eyes, tongue and mouth—N.A.D.

P.R.—Small quantity of meconium noted around anus. Anus too small to accommodate little finger; size 14 catheter could only be passed 1 in. because of some obstruction. Meconium passed after procedure.

C.N.S.—Cranial nerves intact, muscle tone poor, movements present and equal. Reflexes all present except for anal.

Investigations

1. Hb. 19.2 g.%=130%
1. Clean urine—N.A.D.
3. X-ray—confirmed diagnosis of imperforate anus. Abdomen showed extensive pneumo-peritoneum due to perforation of a hollow viscus. (Fig. 1.)

Anthony was admitted into hospital on June 18, at 6.45 in the evening, with a provisional diagnosis of meconium ileus. He was baptised by the chaplain and his parent's consent obtained for an anaesthetic, after an explanation of what was to be done.

A Levine's tube was passed and left in position and gastric lavage performed. The pre-medication given was atropine, gr. $\frac{1}{100}$.

Operation 1

Laparotomy under general anaesthetic. Perforation of transverse colon, pneumo-peritoneum was confirmed, with meconium peritonitis. No signs of obstruction and the meconium was normal in consistency. Transverse colostomy was performed.

Condition on return to ward fairly satisfactory, colour pale. Pulse 152, respirations 56; I.V. transfusion of half-strength Hartmann's solution was begun.

First post-operative day. Half-hourly apex beat, hourly T.P.R. Hourly gastric aspiration and treatment of mouth. I.V. fluid continued—100 cc. every 6 hours. I.M. terramycin, 20 mg. (6-hourly for 2 days then twice daily for 2 days). Paul's tubing from colostomy draining into bedside bottle. Passing urine satisfactorily. Dressing—Nobecutane over suture line; Tulle Gras to colostomy.

The baby made a good recovery—normal feeding started on the second day with ½ oz. sterile water 2-hourly gradually increasing, then feeds of diluted condensed milk. I.V. transfusion discontinued on the third day. Baby well hydrated. Paul's tubing removed on the fourth day, sutures on the seventh day and glass rod on the eighth day. All satisfactory.

For two months Anthony gained weight and the colostomy worked well. There were some slight complications; a discharging right eye was found to have a staphylococcal infection and was treated with chloromycetin; a chesty cough and raised temperature were treated with a course of streptomycin and penicillin injections and soreness around the colostomy site was relieved by applications of zinc and castor oil to produce a waterproof covering and rolled oats applied to absorb the enzymes from the intestine.

Preparation for the closure of the colostomy was delayed twice because of chest infection.

Pre-operative Care

I.M. Imferon, 10 mg., given alternate days—seven doses. Phthalylsulphathiazole, 0.25 g., given for four days. I.M. Synkavit, 5 mg., given to absorb vitamins after phthalylsulphathiazole. I.V. cut down for blood transfusion—100 cc. Hb. 108%. Pre-

Fig. 1. *X-ray on June 18 showing extensive pneumo-peritoneum.*

medication, atropine, gr. $\frac{1}{150}$ (August 10).

Operation 2

Closure of colostomy under general anaesthetic. Five-day course of penicillin, 100,000 units 8-hourly. Streptomycin, ¼ g. twice daily.

Wound healed satisfactorily—drain out after 48 hours, sutures on seventh day. Feeds taken well. Baby passing normal stools per rectum. Twelve days later there were signs of intestinal obstruction—loss of appetite, continuous vomiting, bowels not opened, previously diarrhoea, visible peristalsis. Plain X-ray suggested obstruction of the small bowel.

Treatment: Levine's tube passed—aspirated frequently. Subcutaneous infusion of half-strength Hartmann's solution, 300 cc., given.

Pre-medication, atropine, gr. $\frac{1}{150}$ (August 22).

Operation 3

Laparotomy under general anaesthetic. Findings—faecal impacting and small adhesions which were divided.

An attempt was made to relieve the obstruction with enemata: (1) olive oil; (2) dioctyl sodium sulpha-succinate—but without success. On August 27 he developed a faecal fistula at the site of his previous transverse colostomy, and a burst abdomen—tension sutures retied over polythene tubing. Hb. 75%. Course of Neoferrum and ascorbic acid given. I.M. Achromycin, 25 mg. 6-hourly, for infected wound; Befortis elixir, 1 drachm t.d.s. Pre-operative subcutaneous infusion of half-strength Hartmann's solution, 200 cc.

Pre-medication, atropine, gr. $\frac{1}{100}$, Nepenthe, 1 minim (August 30).

Operation 4

Performed because no improvement of wound. Abdominal wound found completely open, no signs of healing. Slough ++—caecostomy performed.

Further lavage of distal colon followed by barium enema showed no obvious organic obstruction. Daily olive oil enema followed by enema simplex given with occasional good results.

September 1. Baby prepared for further operation. I.V. cut down for blood transfusion performed; 200 cc. given. Nepenthe, 1 minim, was given and later chloral hydrate, gr. 1, to prevent baby from becoming restless and distressed.

September 3. Hb. 103%; WBC 17,000. Caecostomy acting well, taking feeds of NDM F/C. Baby gaining weight—10 lb. 2 oz.

Pre-medication, atropine, gr. $\frac{1}{100}$ (October 3).

Operation 5

Biopsy of rectal mucosa—showed no ganglion cells but many abnormal nerve fibres. Consistent with Hirschsprung's disease.

Daily olive oil enemata followed by simple enemata continued but baby lost appetite and began losing weight. Given further course of Imferon. I.M. injections difficult to perform due to emaciation of baby. Several days later baby developed a large swelling of right buttock—soon resolved after a course of Achromycin, 31.125 mg. 6-hourly.

Caecostomy performing fairly well. Further faecal fistula appeared from colostomy wound, discharging pus and faeces. Four smaller fistulae appeared, as in the formation of abscesses. Whole abdomen very red and inflamed.

Baby reluctant to feed. Evaporated milk offered 2-hourly in small amounts. Temperature elevated. Further course of Achromycin ordered.

Pre-operative care. Syrup of chloral, gr. 3, given prior to I.V. cut down for blood transfusion. 200 cc. given followed by half-strength Hartmann's solution. (Fig. 2.)

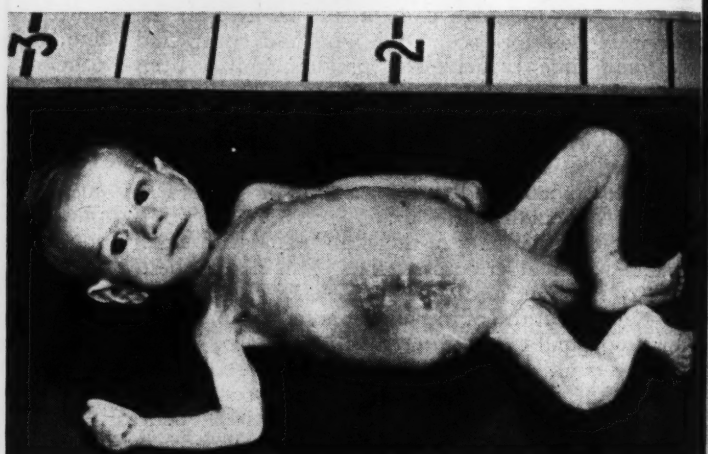


Fig. 2. *Anthony on November 5, two days before his sixth operation.*

Operation 6

November 7. Laparotomy—showed ascending and transverse colon grossly distended with scybalous masses tapering off gradually just below splenic flexure. At this point bowel was firmly adherent to lateral diaphragm and abdominal wall, with a small pus collection suggesting old perforation. Four separate loops of bowel were found to be adhering to this spot and another adhering to the caecum. Two of these adherent loops required resection and end-to-end anastomosis. Transverse colostomy was performed.

Baby very shocked on return to ward; skin grey and cold, colour cyanosed and pulse almost imperceptible. Nursed in Oxygenaire incubator with continuous oxygen. (Fig. 3.)

Half-hourly pulse chart, hourly T.P.R. Nil by mouth. Levine's tube aspirated half-hourly at first and then continuously. Turned 2-hourly, mouth treated hourly. Developed swelling of right parotid gland. I.V. half-strength Hartmann's solution followed by 300 cc. of blood, recorded hourly. I.M. Achromycin, 50 mg. 6-

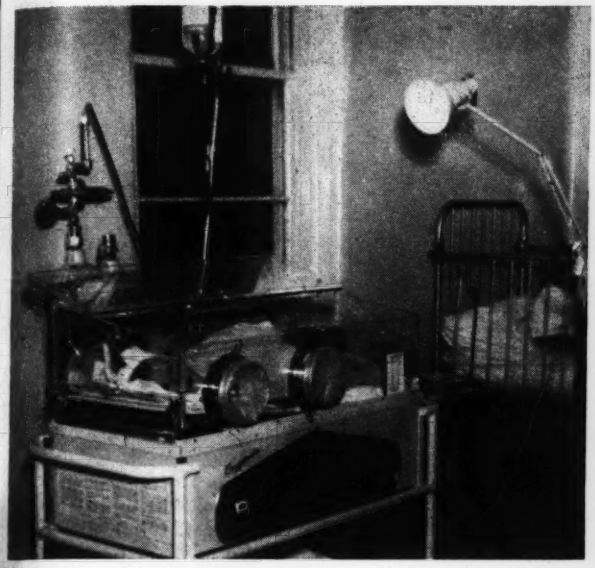


Fig. 3. *In the Oxygenaire incubator on November 8.*

hourly. Wound redressed P.R.N.

Anthony became very congested next day. Achromycin discontinued. I.M. streptomycin, 0.25 g., and penicillin, 125,000 units, given 6-hourly. ? Bronchitis.

Baby recovered well. Oxygen discontinued second day after operation. I.V. fluids continued until further 200 cc. of blood had been given then discontinued, also gastric suction. Second day baby offered half-strength Hartmann's solution sweetened with glucose, then quarter-strength evaporated milk, gradually increasing in strength and quantity.

Fourth day when dressing of caecostomy and colostomy was performed, found to have a burst laparotomy incision, skin surface only.

November 11. Pre-medication, atropine, gr. $\frac{1}{100}$ with Hyalase. Gastric lavage performed.

Operation 7

Wound resutured under general anaesthetic. Condition satisfactory on return to ward. Feeding started 3 hours after—2 oz. half-strength Hartmann's solution. Penicillin and streptomycin discontinued. Albamycin, 62.5 mg. 6-hourly, ordered following report on swab taken from wound. Organisms found were Staphylococcus pyogenes and non-haemolytic streptococcus.

First day: baby satisfactory until evening when he became very pale, respirations very slow, eyes rolling, vomiting slightly—? convulsion. Unconscious for 10-15 minutes but slept peacefully after.

Abdominal wound appeared very inflamed. Colostomy, caecostomy and fistulae all discharging++ yellow stools.

November 13. A macular rash appeared on baby's trunk lasting several hours only.

Olive oil was given via colostomy and caecostomy daily but faeces became impacted++between the two.

November 27. Sudden haemorrhage appeared from fistulae and colostomy. Quite forceful at first. Firm binder applied over dressing. Careful watch kept for re-occurrence. Hb. 82%, WBC 28,000. Loss of weight —he now weighed 8 lb. 5 oz.

Pre-medication, atropine, gr. $\frac{1}{100}$ (November 28).

Operation 8

Digital removal of impacted faeces.

Day after, abdomen grossly inflamed, 'blistered' and blue—acute cellulitis. Dressed very frequently with Tulle Gras and silicone cream. Loss of appetite and vomiting. Two-hourly feeds 2½ oz. milk offered.

Neomycin, 0.1 g. t.d.s. Achromycin, 31.125 mg. 6-hourly. Caused vomiting, replaced by Sulphamezathine, 0.25 g. 6-hourly. General condition of baby poor. Holy Unction given by vicar.

December 8. Baby taking feeds much better. 3 oz. evaporated milk offered 2-hourly. Physiotherapy treatment for chest congestion. Baby turned 2-hourly.

Cellulitis improved slowly after treatment with hydrogen peroxide. Large fistula from previous colostomy acting well, colostomy and caecostomy functioning very little. Baby's condition improved until fistula gradually closed.

Olive oil passed daily into caecostomy; dioctyl sodium sulpha-succinate given t.d.s. After treatment caecostomy and fistula functioning well. Baby gaining weight and feeding well. Taking 4 oz. milk 3-hourly plus Heinz strained food once a day with Delrosa.

December 26. Baby's weight 10 lb. 6 oz. Well and happy.

December 27. Sudden decline in condition. Vomiting ++bile-stained fluid. Abdomen not distended and fistula not functioning. Pus discharging from fistula. Anthony was very ill. ? Intra-abdominal abscess—partial obstruction.

Treatment. Continuous gastric suction via Levine's tube—intermittent suction second day, discontinued on third day after sudden relapse. Subcutaneous infusion half-strength Hartmann's solution, 100 cc., given. Baby very fretful; syrup of chloral, gr. 2, given during procedure.

Oral feeding started approximately 8 hours after when very little was being aspirated. 1 oz. half-strength Hartmann's solution and glucose given 2-hourly, gradually increasing amount until back to milk feeds within three days.

Olive oil enemata improved action of caecostomy. Baby continued to gain weight and general condition improved although he vomited intermittently for no apparent reason.

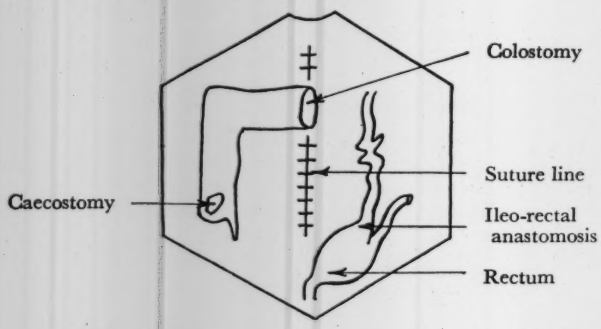
January 23. Levine's tube passed and left *in situ*. I.V. cut down performed in ward for transfusion. Blood given by positive pressure before going to theatre.

Pre-medication H.I. atropine, gr. $\frac{1}{100}$.

Operation 9

Laparotomy—by excising previous right para-median wound and terminal colostomy. Transverse colon re-

sected. Ileo-rectal anastomosis performed, leaving a redundant ascending colon opening at both ends onto the skin and which in time should atrophy.



Nursing Care on Return to Ward

(1) Baby nursed in oxygen tent for 24 hours. (2) Continuous gastric suction necessary for first 12 hours then intermittently when normal feeding was begun—1 oz. sterile water hourly. (3) Mouth very dry —treated with glycerine. (4) Baby turned 2-hourly to avoid chest complications. (5) I.V. fluids given for 48 hours: blood, 250 cc., normal saline, 100 cc. (in theatre); dextrose 5%, 275 cc. Subcutaneously on third day, 660 cc. of half-strength Hartmann's solution. (6) I.M. penicillin, 125,000 cc. 6-hourly, I.M. streptomycin, 0.25 g. b.d, (seven days).

Baby lost 1 lb. in weight over this period. A good recovery was made. Fairly loose stools passed per rectum but also through the pelvic 'overflow' colostomy.

Pre-medication, atropine, gr. $\frac{1}{100}$ (February 27).

Operation 10

Closure of mucus fistula (overflow colostomy) in LIF. Penicillin, 125,000 units, streptomycin, $\frac{1}{4}$ g., given post-operatively for 5 days.

Continued to make progress until one week later. Unable to retain feeds. Became very dehydrated. Subcutaneous fluid given—500 cc. half-strength Hartmann's solution.

Investigations. Faeces and blood—N.A.D.; urine—indole++ ? Stasis of intestine; throat swab—Staphylococcus aureus ++++, sensitive only to chloromycetin and erythromycin; mouth swab—Monilia albicans.

Treatment. (1) Barrier precautions; (2) Erythromycin, 60 mg. 6-hourly 6 days; (3) mouth painted with gentian violet 1% t.d.s. for 4 days.

Improvement within 5 days. For 3 months marked improvement: gaining weight, appetite good—solids being taken, teething, able to sit, alert and happy. There were occasional relapses when abdomen became distended and baby was unable to retain feeds, pyrexia. Small fluid stools passed causing very sore buttocks.

Treatment. (1) Firm abdominal binder; (2) glycerin or Ducolax suppository—occasionally dioctyl sodium sulpha-succinate enemata, 1%; (3) half-strength cow's milk or half-strength Hartmann's solution to retain hydration; (4) sore buttocks—tannic acid in spirit, 1 in 8 solution.

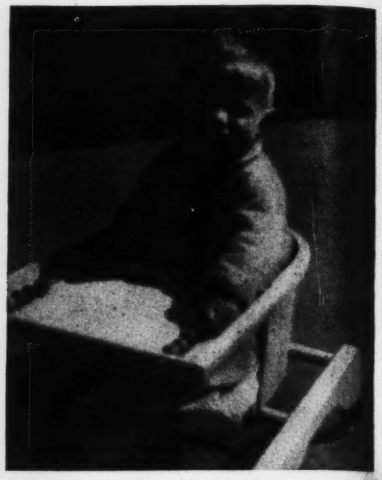


Fig. 4. *Anthony on May 16, 1958, at 11½ months.*

Anthony was discharged on May 16. He weighed 14 lb. 2 oz. Age 11 months 4 days. He was to return later for removal of remaining colon. (Fig. 4.)

Summary

The cause of Hirschsprung's disease remains unknown. There had been no congenital abnormalities or disease in the five previous children of this family and the mother had an uneventful pregnancy, apart from a breech delivery.

Hirschsprung's disease was diagnosed by rectal biopsy taken at the baby's fifth operation, at the age of 4½ months. This baby underwent 10 operations in his first eight months of life. Complications often arose due to his lowered resistance to infection. It is still a mystery why, when the child was suffering from Hirschsprung's disease and had no signs of intestinal obstruction, he should have a perforated transverse colon at birth.

Anthony's prognosis is now fairly good; he defaecates normally, having an ileo-rectal anastomosis, and when he is older he will be admitted to hospital for removal of the remaining defunctioned colon.

This was a most interesting and satisfying case and, it is hoped, he will continue to make satisfactory progress.

[I would like to express my appreciation and thanks to Mr. C. P. Sames for allowing the case history to go forward, and also to Anthony's mother for allowing us to publish his photographs.]

The Hospital Year Book, 1959

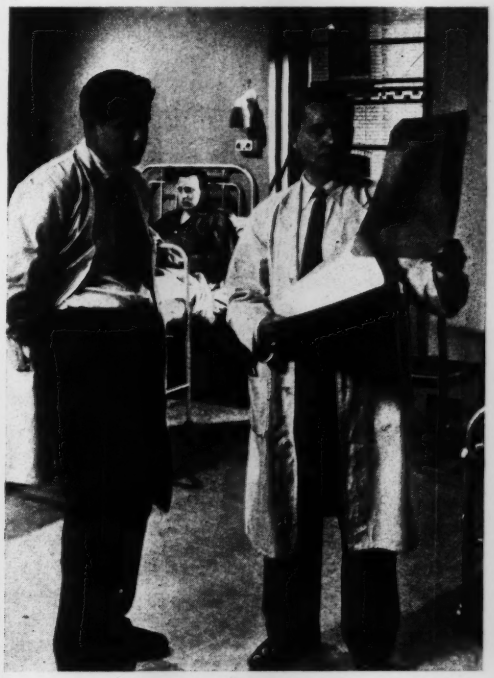
ONCE AGAIN a mine of useful reference information is brought up to date in the new edition of *The Hospitals Year Book**. Its 1,125 pages contain well set out and classified material invaluable to those in all branches of administration within or ancillary to the health services. In the foreword, the editor reviews the first decade of the National Health Service; the section 'The Next 10 Years' gives an interesting and enlightened forecast on development of current trends which will profoundly affect medical, nursing and administrative planning and activities in the immediate future.

**Edited by J. F. Milne, B.Sc. (Econ.); advisory editor, S. R. Speller, LL.B. Published by the Institute of Hospital Administrators; price 57s. 6d.*

'Emergency—Ward 10'

Emergency—Ward 10, with 20,000,000 viewers a week, is a programme in which great pains are taken to ensure the accuracy of the hospital 'set'. This is the rehearsal of a scene in which a nurse specialling a patient with respiratory paralysis is watching the positive pressure respirator.

Emergency—Ward 10 stresses the importance of a good doctor/patient relationship. Oxbridge is a hospital exemplifying the team spirit.

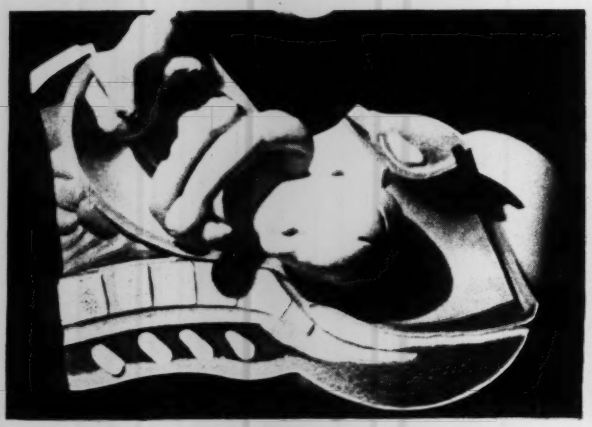


R.S.O. to medical registrar "Yes—a pretty good picture. It's rare to find so many cysts in one chest."

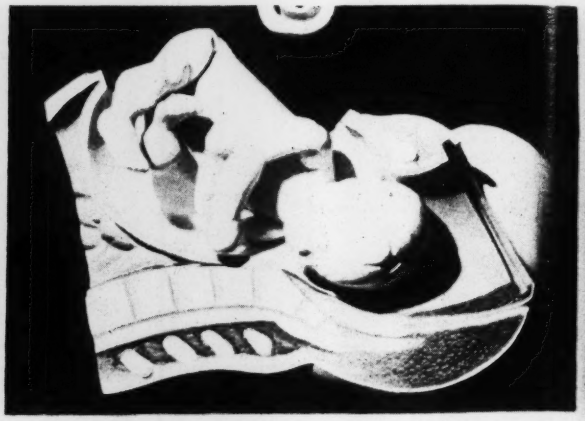
From the popular ATV Serial

But discipline must be maintained, and the home sister does not look kindly on nurses who stay out without leave.

The porter is welcomed and thanked by the ward sister for bringing a television set into the ward for Christmas.

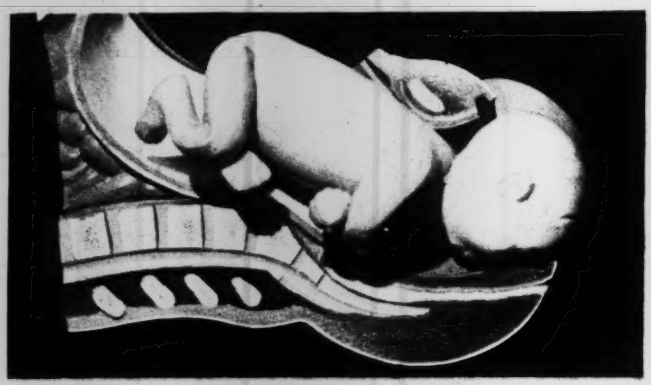


1. *ONSET OF LABOUR. The cervix admits one finger and the head is engaged in the pelvic brim. Vertex presentation, left occipito-lateral position.*

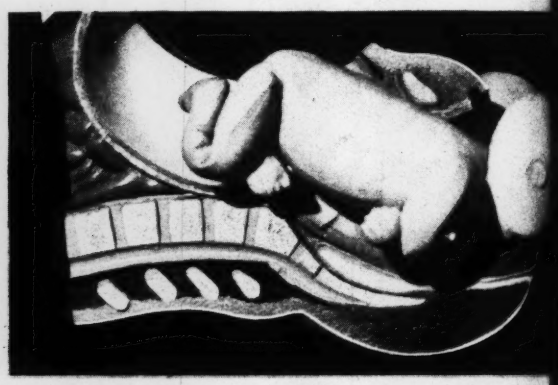


2. *EARLY LABOUR. The head is beginning to descend and has undergone internal rotation to left occipito-anterior position.*

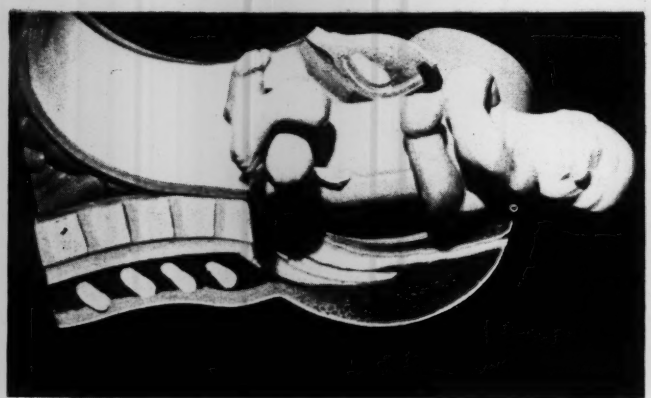
THE MECHANISM OF LABOUR



5. *SECOND STAGE OF LABOUR. The cervix is fully dilated; the head has descended on the perineum and is beginning to extend around the sub-occipital point.*

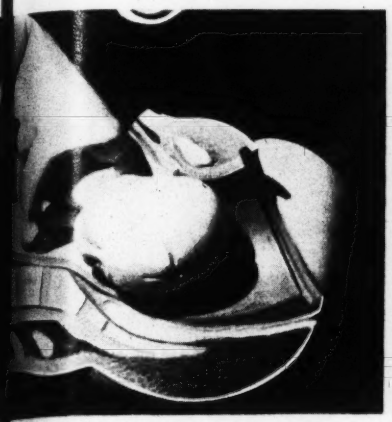


6. *The crowning of the head has been completed by slipping vulva over the parietal eminences. The head is partially ex and the perineum has passed over the brow and upper the face.*

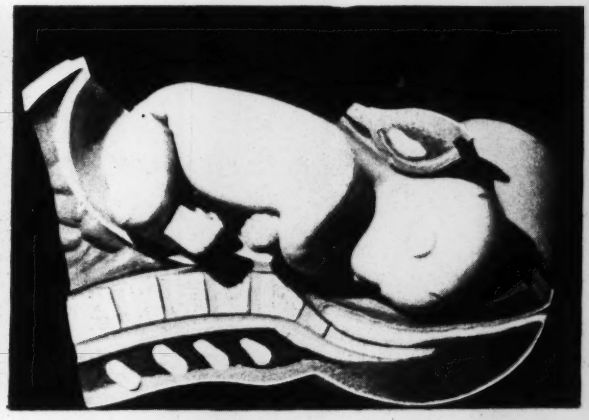


9. *Gentle lateral flexion of the neck is effected by gentle traction to the head and the anterior shoulder is born beneath the symphysis pubis.*

10. *The head is now pulled forwards towards the mot abdomen and the posterior shoulder is born over the perin*



E OF LABOUR. The cervix is now half has descended to midcavity and internal rotation is proceeding.



4. *LATE FIRST STAGE. The cervix is now three-quarters dilated and internal rotation is complete. The head is below the ischial spines and in the occipito-anterior position.*

CAMERA TALKS
production supervised by Mr. J. M. Holmes, M.D., M.R.C.O.G.
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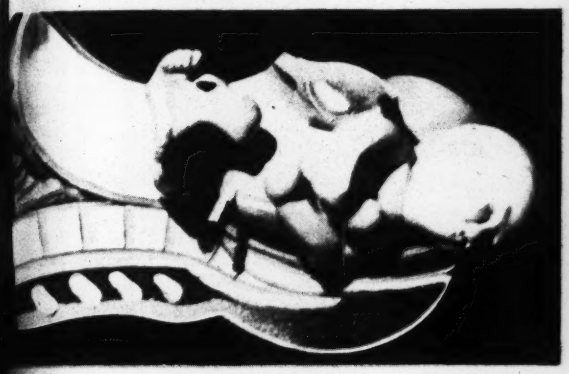
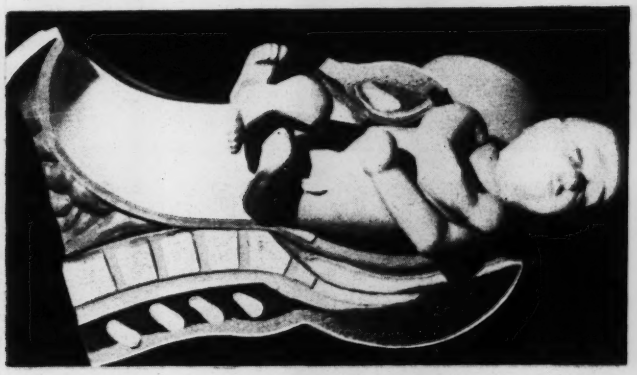
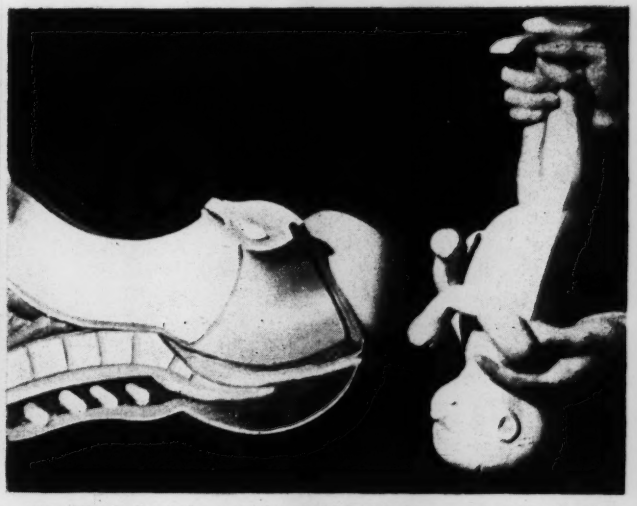


The head has been delivered and undergone restitution through 45° to the left occipito-anterior position.



8. *External rotation is now complete. The head has rotated through a further 45° and this has brought the shoulders antero-posterior.*

1. Further traction towards the abdomen effects easy delivery of the foetal trunk.

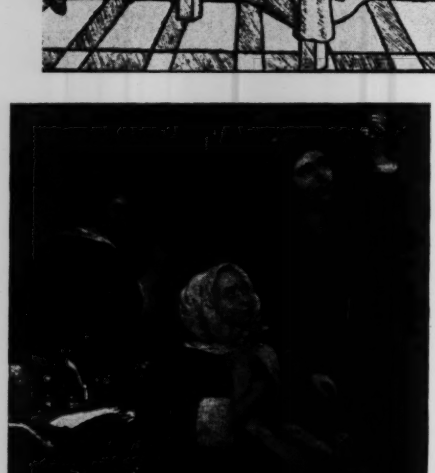


12. *The baby is born and is held head downwards. One hand grasps the legs with the forefinger between the ankles. Additional support can be given by two fingers beneath the shoulders.*

General Practitioners through Four Centuries

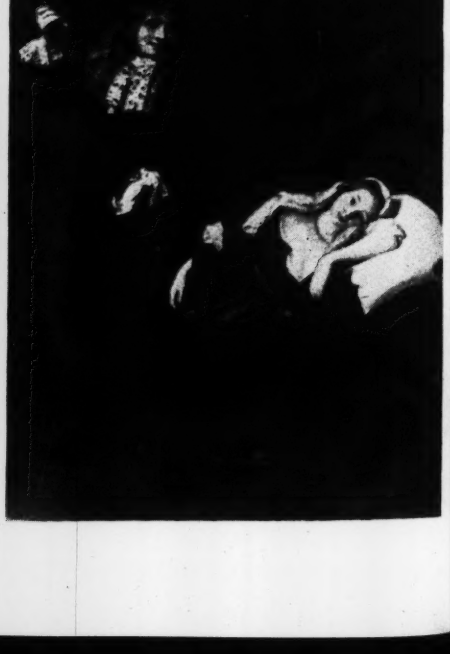
◀ *A German 'wonder-chirurg' and his young assistants visit a badly-wounded patient during the middle of the 15th century.*

▲ *A Russian doctor at the beginning of the 18th century calls on the daughter of a nobleman. She is suffering from 'emotional melancholy'.*



▼ *A young Viennese doctor in the mid-18th century visiting his young patient and giving her 'medical advises' after examining her urine.*

▲ *A visiting German doctor taking blood from his patient at the beginning of the 16th century.*



▲ *A French doctor at the beginning of the 18th century examines the urine of a young woman patient.*

▶ *A Czech doctor making out a prescription in the home of a patient during the second half of the 18th century.*

The College of General Practitioners

J. P. HORDER, M.R.C.P., General Practitioner, Honorary Archivist of the College

THE MOST INTERESTING single fact about the College of General Practitioners is that it has been created. One might well ask why this should happen in 1952 when general practitioners are the most ancient form of doctor. That similar bodies should emerge in the United States, Canada and Australia makes the happening only more significant.

Every nurse and every doctor, whatever their work, has at some point been challenged by the very great expansion of medical knowledge that has occurred in the last 80 years. One answer to the challenge has been a great increase in specialization; there are now at least 30 different sorts of specialists whereas in 1880 there were six. This is essential and inevitable, but for the general practitioner it has made a second challenge: has he any longer a place in medicine alongside the specialists?

This second challenge has become more and more clearly defined as specialties have developed. The answer to the challenge has also become clearer. The more medicine has become fragmented, the more obvious has seemed the need for doctors who can see the wood despite the trees. The more efficient the specialist has become, the more significant has become the comment of the four-year-old who shouted from across the road one morning, "Mummy, there's *my* doctor!"

In our present society we are dependent in every field on technicians and specialists, but it is noticeable that it is not they who are given the ultimate responsibility for the most important decisions. We still rely on wise men with wide experience. The best hope for the future lies in co-operation between the two. So also is it in medicine.

It is against this background that the College of General Practitioners came into being.

Purpose and Symbol

The College was created in order to improve the standard of general practice and to represent general practitioners to other academic bodies. As will be seen later, there are other aims which are additional but less important. Perhaps the real meaning of the College is this: it is an outward symbol that family doctoring is a discipline in which it is worth while for a man to make himself a perpetual student.

The College has members and associates in the United Kingdom, Eire and many parts of the Commonwealth. They now number 4,530. Membership is obtainable by election after a certain length of time in active general practice; associateship is more widely open.

Members and associates meet together several times yearly in regional faculties, which are the basic elements of the organization. The boundaries of each faculty are, where possible, small enough to make meetings practicable, yet large enough to include at least one university medical school. An example is the East Anglia faculty which includes four counties and has a liaison with the medical school at Cambridge.

An artist's impression of the new headquarters of the College of General Practitioners, to be built alongside the Royal College of Surgeons in Lincoln's Inn Fields.

End of Isolation

The chief purpose of faculty meetings is to end the isolation which has been such a disadvantage to family doctors in the past. This is replaced by the stimulation which naturally results when people with the same work meet together. The central theme of faculty meetings is postgraduate education. There is an emphasis on discussion and contributions by general practitioners themselves; not infrequently the contributions are original observations. Purely social occasions also have their place. Some faculties publish a journal or news letter of their own.

The College has a central organization which is partly, but not entirely, in London. The College Council meets at the headquarters in London, but the Scottish Council meets in Edinburgh and the New Zealand Council in different cities in New Zealand. The research committee of the Council is directed from Birmingham. The *Journal of the College of General Practitioners* is edited from Devonshire. The central headquarters, which existed for five years in one room, now temporarily occupies a large house in Chelsea. Here are the secretariat, the beginnings of a library and museum, council committee rooms, and rooms where a few members may lodge when attending meetings.

A generous and anonymous donor has provided the means for a fine permanent building. The Royal College of Surgeons has offered a site in Lincoln's Inn Fields be-

NURSING TIMES TRAVEL BURSARY

Application forms and particulars of the *Nursing Times* Travel Bursary may be obtained from the editor. Application forms must be returned to the Editor, *Nursing Times*, St. Martin's Street, London, W.C.2, in an envelope marked '*Nursing Times Bursary*' by **Saturday, February 28.**

side its own building.

For most members and associates their continuing education is the College activity which seems to them most important; this is carried out through personal contact, faculty lectures, central conferences and college publications.

A smaller but active number of members has pursued research in general practice. Group research, in particular, has been encouraged or organized. Valuable studies have been made in obstetrics, measles, chest disease and epidemiology. The largest study, involving 100 practices, has been the general survey of morbidity during one year which was made in co-operation with the General Register Office.

The undergraduate education of all doctors is the third main concern of the College. In the past some of the facets of medicine which are most obvious to the general practitioner have been totally neglected i undergraduate teaching, which has been too exclusivel concerned with diseases seen in hospital and wit patients divorced from their own surroundings. Th College has already been influential in arranging tha many medical students spend a short period seeing general practitioner at his work.

The College journal started as a typescript for privat circulation among members and associates on the Re search Register; it has rapidly become a quarterl publication, partly of original papers, partly of report of College activities.

The College has already been consulted on numerou occasions by other bodies wanting to find out the view of general practitioners as a group. Politics—remunera tion in particular—are excluded from its work.

The success of the College among general practitioner is witnessed by its steadily increasing membership an steadily expanding work. The welcome which it ha received from other bodies could not have been pre dicted and has been most gratifying. General practition ers needed this symbol of their ideals and they hav responded by revealing a fund of untapped energy which, we believe, is already enabling the College t make a significant contribution to the welfare of sic people.

TALKING POINT

As INQUIRIES come in from our readers about our travel bursary there has been much conversation in the office as to how the £500 could be spent. Not being a prospective candidate I can indulge myself to the full in speculation as to how I would spend it. Without hesitation I would choose to go to China, and see it before the mimosa dust settles for all time.

1959 has been prophesied as China's year. A country of three million square miles with a population of 600 million people, China has a rapidly expanding economy, a rising standard of living, an increasing birth rate and a falling death rate. The Chinese industrial and scientific revolution which is taking place at this minute may well dwarf the Russian achievements.

Westerners may view these changes with understandable apprehension but to ignore them is unrealistic. Communist ideologies are repugnant to democracies; especially to those of us enjoying a moderately high standard of living. It is interesting to wonder how far each of us, in Russia or in China, would toe the party line. Chinese communes, groups of villages united under a single overlord or government representative, seem strange to property-owning-democrats used to three square meals a day; but if communal feeding means having two meat meals a week instead of two meat meals a year, democratic ideologies may take second place to ideas of sustenance alone.

What is the position of the Chinese nurse? A nation that 10 years ago never manufactured an aspirin is now producing penicillin in quantity. We have some idea of the structure of Russian nursing from recent visits of nurses. Someone has said that we still don't know know long a Russian nurse's training takes; but would a visitor from Russia grasp the complexities of our own training schemes, which range from two years for a State-enrolled assistant nurse to four years and nine months for a comprehensive integrated scheme for a health visitor? We know that in Russia nursing is regarded as subservient to medicine and not complementary to it, because many good nurses, as a reward go on to take their medical training; more than half the doctors in Russia are women.

What happens in China? Has anyone been there as a visiting nurse in the last two years? One is aware of the work in the mission field in China, but now that most missionaries have left do we know the pattern that nursing is following? China is not in membership with the ICN, so the usual international contacts in nursing are not open to us.

I wonder if any of our applicants for the bursary will think of going East instead of West? It would be an interesting, exciting and infinitely stimulating experience for a British nurse; incidentally, it would probably be extremely difficult to arrange. But I have no doubt that it would be tremendously rewarding to the individual and it could not fail to be of very great interest to all nurses in the West.

* * *

It is with regret that I must inform readers of Talking Point that I have misled them. Last week I wrote: "Yet almost any nurse is allowed to train pupil assistant nurses; three month's course at Birmingham and away you go to train these admirable women in their dozens."

I should have written "*one* month's course."

WRANGLER.

ROYAL COLLEGE OF NURSING

Council Meeting, January 1959

FOLLOWING HER New Year greetings to the members of the Council, the chairman, Mrs. Woodman, expressed the pleasure of the College at the award of the O.B.E. to Miss Marriott, president, and of honours to a number of other members and friends of the College. The Council were delighted to learn of the generous gift by an anonymous donor who had presented two roving microphones for use in the Cowdray Hall.

Pattern of Nurse Training

One of the most important subjects discussed by the Council was the future pattern of nurse training. Great changes had taken place over recent years, not only through the National Health Service, the extension of medical and scientific knowledge and the fact that the Register of Nurses was now one Register with several parts, but also because of alterations in the nursing needs of the community and social developments, including the Education Act of 1944.

Now that the General Certificate of Education could be obtained either at school or by subsequent educational schemes, a minimum educational standard for entry to nurse training should be a basic requirement, but other essentials for future nurse training were not so clear cut. The Council agreed that a special committee should be appointed, in due course, to make an extensive study of the pattern of nurse education, but in the meantime the Council authorized a small group to carry out a preliminary study in order to clarify the position and analyse the various terms now in use, such as 'comprehensive', 'integrated' and 'combined' training schemes.

Representation of the College on the liaison committee with the British Medical Association was considered in preparation for a meeting on February 3. It had been agreed that a College officer should be appointed to act as joint secretary to this committee.

Miss Hall presented the report of the Labour Relations Committee, which had met under its chairman, Sir Frederick Leggett. A number of matters relating to nurses' salaries and conditions of work had been fully discussed and action recommended which the Council endorsed.

Miss Houghton, chairman of the Education Committee, reported on the results of the recent examinations in London and Edinburgh for the Ward Sister's Certificate of the College, and the Education Department and the Scottish Board were congratulated on the results (see page 118).

Miss Wearn referred to the seminar called by the Public Health Section to prepare a report on health education of the public,which was the topic for the Technical Discussions at the World Health Assembly in Geneva. Recognizing the increasingly important part health visitors were taking in health education in this country, the Council agreed that the report should be sent forward to the World Health Organization through the appropriate channels.

Miss Townsend presented the report of the last meeting of the Representative Committee of Affiliated Organizations. The Association of British Paediatric Nurses was planning, with the National Council of Nurses, an international paediatric study tour which would be held in London in May. A member of the Association, Miss M. W. Janes, had been appointed a member of the committee set up to inquire into the Welfare of Children in Hospital. The Society of Registered Male Nurses had discussed a number of matters at their annual conference last autumn, including the implementation of the 88-hour fortnight and the problems that might arise in the event of one professional organization offering membership to all nurses.

The Society of Mental Nurses was holding a course in group dynamics at the College under the leadership of Dr. Stauble, which was proving most stimulating. The National Association of State Enrolled Assistant Nurses reported that the duties and responsibilities of State-enrolled assistant nurses in industrial medical departments were being studied.

Miss Keddie presented the report of the Scottish Board and the Council was gratified to learn that the board of management of Dundee Royal Mental Hospitals had agreed that as from January 1, 1959, matrons of the mental hospitals were to be directly responsible to the board of management, attending appropriate committees of the board and the full board meeting. This was an example of the progress being made in establishing the appropriate relationship between matrons and hospital authorities. Some 70 ward sisters in Scotland had attended a successful area meeting which took the form of a symposium on 'The Basic Principles of Nursing Care'.

Northern Ireland News

The Committee for Northern Ireland reported that the Nurses' Regulations (Northern Ireland) 1958 became effective on December 23, 1958; they made provision for safeguarding the title 'nurse' under Section 6 of the Nurses Act (N.I.) 1946. The Health Committees of Belfast and Londonderry Corporations had submitted schemes to the Ministry of Health by which a general health visiting service might be operated in future, combining the school health service with maternity and child welfare services. Having approved the schemes the Ministry had also approved the payment on the agreed scale for health visitors, or school nurses who were qualified health visitors—the salaries to be paid with retrospective effect to July 1, 1957.

The Council approved the budget for 1959, presented by Miss Dey, hon. treasurer. A grant of £20 had been made to a member from the Sick Nurses Fund.

An offer from the Williams Deacon's Bank Ltd. to extend banking concessions to College members similar to those offered by a number of other banks was accepted with appreciation.

The transfer of a number of newly qualified nurses from the Student Nurses' Association to the College was welcomed; this group formed 46.5 per cent. of the applications for membership during the current month.

The Council was also encouraged by the fact that the report on the problem of providing a continuous nursing service especially in relation to night duty had been in great demand and a reprint was needed as only a few of the first 5,000 copies remained.

Miss L. Montgomery, northern area organizer, and Miss D. Davies, Occupational Health Section secretary, were authorized to attend the Royal Society of Health Congress in Harrogate in April.

The date of the next meeting is February 19.

Prevention of Scale Formation in Hot Water Sterilizers

R. WORTHINGTON and J. A. GATLEY

WHEN THE NEW MEDICAL CENTRE of Joseph Crosfield and Sons Ltd. was opened the staff decided to tackle the problem of scale formation in the hot water sterilizer. As is usually the case, scale had previously caused the sterilizer and instruments to look unsightly and the tedious job of cleaning had to be carried out fairly frequently.

By using conventional water treatment methods which are now part of the routine of the centre, the scale formation has been eliminated completely.

It was thought worth while to report the results fully in view of the interest aroused and because solving the problem did not prove as straightforward as anticipated. In order to eliminate the problem completely, it was found necessary to use two water treatment processes. These processes are used conjointly and are known as base exchange softening and sequestration.

How are Scales Formed?

On boiling water scales are formed by the precipitation of the temporary hardness, calcium bicarbonate being in solution. Decomposition of calcium bicarbonate takes place on boiling, with the formation of the very much less soluble calcium carbonate. This deposits from the water as scale which adheres to the sides of sterilizers, or other surfaces with which the water comes into contact, to form hard layers which gradually build up in thickness, thus progressively reducing the efficiency of any heating surface as well as looking unsightly.

The greater the amount of temporary hardness in a water and the higher the temperature at which it is heated, the greater the rate and extent of scale formation which would be expected. However, in determining the rate and extent of formation of scale much depends upon other characteristics of the water supply as well as the conditions under which it is boiled; the metal surface with which the water is in contact also plays a part.

How can Scales be Prevented?

A simple method of removing the scale-forming substance from the water is to pass the water through a base exchange softening material. Such a material is granular or bead form in appearance and is usually of $^1/_{16}$ in. to $^1/_{50}$ in. particle size. The base exchange material is contained in the familiar domestic softening unit, of which there are both portable and mains type models. By passing water, usually in a downward direction, through such a unit the calcium bicarbonate which is present is converted into sodium bicarbonate which is very soluble in water. A deposit does not therefore occur.

After a period the effectiveness of the base exchange material for removing hardness becomes exhausted and at this stage the softening unit is regenerated by passing through it a solution of common salt in water in a downward direction and then washing out the excess salt to waste.

Apart from the softening and regeneration processes one other stage is involved in operating a softening unit. This is backflushing which is carried out immediately before regeneration by passing water upward through the unit. By this means the base exchange material bed is loosened and even passage of water during the regeneration and softening cycles is facilitated.

Abstract of an article in the 'Journal for Industrial Nurses' Vol. X, No. 3, 1958, reproduced by permission of the editor and authors.

The Problem at Warrington

Before using softened water there was heavy scaling of the sterilizer because it was used on a water supply of a temporary hardness of 200 p.p.m. $CaCO_3$, that is, about 0.02 lb. of calcium carbonate scale could form from every 10 gallons of water. Scaling, in fact, occurred both on the sides of the sterilizer and also upon the instruments and bowls being sterilized. The instruments and bowls are made of stainless steel and the sterilizer is of tinned copper.

A portable domestic type base exchange water softening unit was used. This resulted in the prevention of the heavy scale formation on the sides of the sterilizer. However, it was noted with some surprise that instruments and bowls still scaled very slightly and were not of the bright appearance expected. A slight white film of scale gave the bowls and instruments a dullish mottled appearance and some cleaning of these pieces of equipment was still required.

In order to investigate further the cause of this slight scaling effect two series of tests were carried out, First, a qualitative examination of the slight scale, and secondly, an analysis of the water in the sterilizer in the morning and evening, that is, shortly after filling and before emptying. The slight white film of scale was apparently caused mainly by the precipitation of calcium silicate due to the reaction of the very slight amount of calcium hardness still present in the softened water with the silica which was also present.

Sequestration and Ethylene-diaminetetracetic Acid (EDTA)

Accordingly it was suggested that to overcome the slight but still troublesome calcium silicate scale a sequestering agent should be used in small amount in the sterilizer water. The preferable material to use would be one which was stable in hot water, such as ethylene-diaminetetracetic acid (EDTA). A level teaspoonful of EDTA in the eight gallon sterilizer was added when filling with hot water each morning.

EDTA is an organic chemical which in aqueous solution has the property of selecting certain metals in solution, for example calcium, to form a complex which remains in solution and no scale will form on heating.

It would be possible to use EDTA to sequester the hardness in water in a sterilizer without the water having been treated beforehand by a base exchange softening unit, but use of the latter greatly reduces costs and it will last many years if used correctly. It is estimated that in the present case using EDTA only would have cost at least £35 per year.

Summary

Scale formation in sterilizers has been completely overcome by softening the water used and also adding a small amount of an organic sequestering agent. A routine has been established which has proved very successful.

The method of treatment makes the tedious regular cleaning of the sterilizers and equipment sterilized therein no longer necessary. In any case the regular cleaning previously required when using hard water did not maintain the instruments and bowls being sterilized in the bright condition desirable. They can now be maintained in this condition without any cleaning.

Continuing his 'By Request' Series on Physiology, Dr. WILLIAM EDWARDS writes this time about—

The Blood

It's certainly 'Thicker than Water'; in fact, a very Complex Substance indeed . . .

BLOOD is the body's transport system, taking oxygen and nutriment to the tissues, removing carbon dioxide and other waste matter. It also maintains the right amount of water in the body, keeps a proper balance between acids and alkalis, and protects us against bacteria. Although it is essential for it to keep fluid while circulating, it mustn't all run away if we cut ourselves, so it has the property of clotting when shed, and of not clotting while in the arteries and veins. A very remarkable and very complicated fluid.

It consists of a yellowish fluid called plasma, suspended in which are myriads of cells called corpuscles: red and white. The total amount in a person is about 6 litres, or just over 12 pints. Besides red and white cells, there are minute cells called platelets. The plasma and the platelets conspire to do the clotting, which is a cunning process.

Plasma contains prothrombin and fibrinogen and calcium. Shed platelets liberate thrombokinase, which reacts with prothrombin and calcium to form thrombin. Thrombin plus fibrinogen forms fibrin, which is the solid material of clot. To prevent any anti-social platelets causing trouble while still in circulation, the blood contains heparin, which inactivates both prothrombin and thrombin.

When blood is taken for transfusion it is important that it shouldn't clot. So we add a trace of sodium citrate, which combines with the calcium, Without calcium—no thrombin; so there you are. It's as simple as that. Or isn't it?

It's worse than that. Thrombokinase is now called thromboplastin by the best people, and it contains two factors, absence of one of which causes haemophilia, absence of the other, Christmas disease, which is nothing to do with a Merry Christmas at all. The first patient diagnosed with it happened to be called Christmas: most confusing. Then there are these purpuric types who haven't got any platelets: thrombocytopenia.

'Cocktail' of Antibodies!

If you let plasma—or blood—clot, it separates out into a solid mass, and a fluid which won't clot. That is, serum. One of the proteins in serum is called gamma globulin. This is a cocktail of antibodies, developed in response to infections, which gives us immunity. Gamma globulin, extracted and put into ampoules, can be used for treating all sorts of infectious diseases which antibiotics won't touch. But it takes an awful lot of blood and time and trouble to make gamma globulin, so we only use it when we have to.

The old-time Spanish grandee had a simple blood test to prove his claim to be 'blue blooded'!

Plasma also contains fats, cholesterol, sugar, urea, amino acids, mineral salts and what-have-you.

Enough of that. What of these cells? There are five million red ones in every cubic millimetre of blood. They are little discs consisting of a membrane containing a solution of haemoglobin. Unlike most cells, they have no nuclei so, like mules, they can't reproduce themselves. They last about a month, till they are overcome by sheer wear and tear, and break up. So they must be continually renewed from their highly fertile parents in the marrow of the bones. Their job is to carry oxygen. In the lungs, purple haemoglobin is turned into red oxyhaemoglobin. In the tissues this process is reversed, so arteries carry red blood out, and veins carry blue blood back. Incidentally, the blue blooded Spaniard was the one with no Moorish ancestry, so his skin was white and the blue veins showed through. He was red enough when you cut him open!

The bone marrow, in order to make red cells properly, requires Vitamin B_{12}, Vitamin C, Iron and Copper, and thyroxine from the thyroid gland. Absence of one of these leads to anaemia. Dead and dying red cells are soaked up by the reticulo-endothelial system, which includes the spleen, thymus, lymphoid tissue, and part of the liver. The haemoglobin in them is economically converted into bile pigment.

White blood cells, otherwise called leucocytes are not nearly as numerous: only 6 to 8 thousand to the cubic millimetre. They are real cells with nuclei, and there are several different sorts of them, such as lymphocytes, polymorphs, eosinophils. These white cells have a useful but rather disgusting habit, of eating bacteria. They just push out a bit of protoplasm, engulf the poor little things, and then digest them. The polymorphs do this best, and during most infections there is an enormous increase in their number—all rushing out to join the feast.

Our defences against infection, then, consist partly of the gamma globulin, which is an antidote to bacterial poisons, and partly of white cells destroying the bacteria themselves.

Pus consists of a lot of white cells which have died from overeating, and a lot of partly digested bacteria.

Lymphocytes are formed in lymphoid tissue (lymphatic glands, tonsils, and so on). Polymorphs come from cells called myelocytes in the bone marrow. Reds stay respectably inside blood vessels, but white cells can wriggle their way through the walls of capillaries, which they do when there's any good food about. If you have a small boil, the tissues around it are just packed with white cells which have left the blood, and are busy localizing the infection for you, so that you shan't get septicaemia.

Blood Feuds!

Just as serum contains 'antibodies' to attack infection, so it contains other antibodies which cordially dislike the red blood cells of some, but not all, other people. Why this should be so is rather obscure, unless you like to suppose we are descended from Shem, Ham, and Japhet. If you are a Shem, your blood doesn't like the blood of Uncle Ham or Uncle Japhet. Let their corpuscles enter your circulation, and they will be 'agglutinated'—clotted off into clumps; which doesn't seem to do any one any good, because it only makes you ill.

However, there it is. According to your genes, you inherit A, B, or O sort of blood. A people have an antibody called anti-B; and B people have one called anti-A. As Group O people haven't got any A or B, their cells can't be agglutinated by anti-A or anti-B, so they are called universal donors.

It has all got terribly complicated since the discovery of a lot of other 'antis', especially that monkey-puzzle, the Rhesus factor, which provides 'antis' called C, c, E, e, and D and is rapidly providing quite a lot more, to the delight of the serologist and the confusion of everyone else.

Big C's have little D's upon their backs to bite 'em
Little D's have lesser E's and so *ad infinitum.*

Don't let it all worry you too much. I said blood was complicated!

STUDENTS' SPECIAL

Weekly Pages for the Younger Nurses

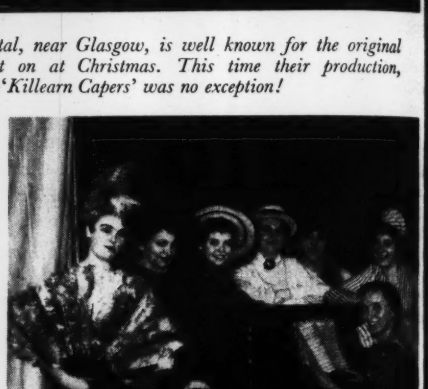
Special performance for the children, of 'Humpty Dumpty', the pantomime given this season by the staff of Queen Mary's Hospital, Carshalton, Surrey.

Killearn Hospital, near Glasgow, is well known for the original shows they put on at Christmas. This time their production, 'Killearn Capers' was no exception!

PANTOS and PLAYS

Put on for Patients, Staff and Friends

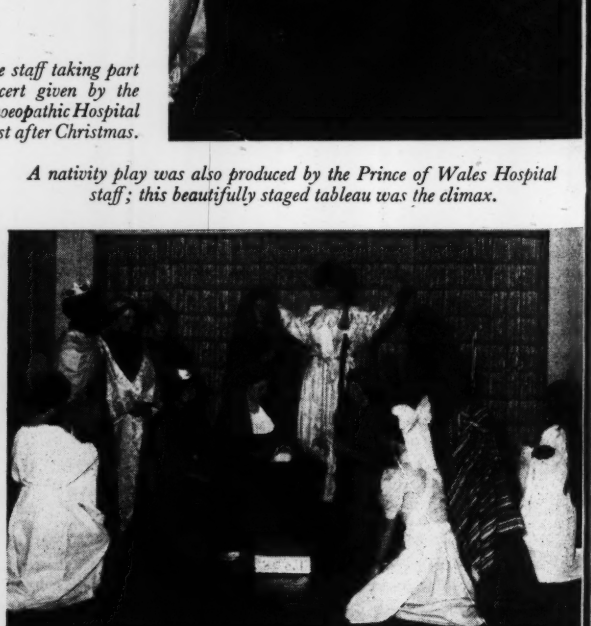
Principal boy and principal girl in the St. Giles' Hospital, Camberwell, production of 'Aladdin and his Wonderful Gamp'.



Some of the staff taking part in the concert given by the Royal Homœopathic Hospital London, just after Christmas.

Discovery of the outsize egg laid by Mother Goose in the pantomime presented by the staff, Prince of Wales Hospital, Tottenham.

A nativity play was also produced by the Prince of Wales Hospital staff; this beautifully staged tableau was the climax.



MORE LETTERS

LIVING LIKE A MATRON

MADAM.—Without comment and with reference to Talking Point of January 9, I report the following verbatim conversation between a consultant and myself.

C. "Do you know the only people who can live like the old aristocracy nowadays?"

M. "No—who?"

C. "Hospital matrons. When friends arrive they just press a bell and order two, three or more meals. Why, when you and I have guests we share our food, wait on our friends and do the washing up afterwards."

M. "I believe they pay a token price for meals, residence, etc., when they have guests."

C. "I know. And I know how much."

Secondly, another specialist with whom I was working told me recently that she and her husband had been entertained to a delightful dinner, waited on by two maids, and that when she and her doctor husband told their friends this, no one could imagine where they'd been. It was the local hospital matron who had entertained them.

Wilts. C.M.

MALE NURSES IN THE FORCES

MADAM.—At a recent meeting the question was raised as to why men S.R.N.s did not receive officer rank in the Services. When I was a member of the Services it was explained to me that women as State-registered nurses had to be given rank, partly because of the other 'non-skilled' women services and ranks. Financially, women officers' pay rates are lower than the male officer rank, also their gratuities are a fairly high percentage lower, as well as pensions. Men nurses are financially probably better off to be in the non-commissioned ranks, and these matters have to be accepted.

London. S.R.N.

THE POLICE AND MIDWIFERY

MADAM.—As a person who is in weekly contact with the police in Kidderminster I was amused at your correspondent's assertion that the police are being taught midwifery. They are not. What in actual fact took place was that one lecture was given by the supervisor of midwives and the subject was treated from the purely first aid point of view. I feel sure, and this is no detriment to the police, that the average male nurse would in an emergency be a much more competent midwife than any of them.

As a male nurse I would like also to add that in my opinion the average male nurse does not want to study midwifery; all he requires is to be given equal chances with his female colleagues.

P. J. ROE, S.R.N., R.M.N., S.T.DIP.

FROM UGANDA

MADAM.—I am most grateful for your letter, and your congratulations on my award of the M.B.E. in the New Year's honours list—which mystifies me, as I have only been matron of this hospital for three years. I presume it is because I have been 25 years in Uganda, though many have done much longer.

Miss M. A. Bond

Actually, I believe it is a recognition of Mengo Hospital, which is the oldest hospital in the whole of Africa, and which pioneered all forms of training; first medical students (now taken over by the government), then midwives in 1919, followed by nurses in 1933. Recently we have trained the first physiotherapy assistant. The hospital was begun in 1897 by the Church Missionary Society, which was responsible for it until last year when it was handed over to a local board of governors who are carefully safeguarding its missionary aims. I think it was this landmark in the hospital and in the country which has been recognized.

It has been a great privilege to have arrived in this country as the nursing profession was established (the first nurses qualified in the month that I arrived) and to have watched the development of these African nurses until today, when a large number are in England, keen enough to take the whole training over again in order to get a British certificate. A few of them have come back and been appointed sisters, and have proved themselves to be well worthy of the posts. We still have very far to go and our aim is recognition by the G.N.C. but meanwhile this hospital has laid the foundations of the tradition of Christian nursing.

MARGARET A. BOND.

SISTER NEEDED

MADAM.—We are writing to you about our very great need at the present time for a senior sister at the Umlazi Mission Hospital at Reunion in Natal. We need someone who would be prepared to act temporarily as matron when the matron is on leave but whose work chiefly would be practical nursing. We desperately badly need an experienced and missionary-hearted woman, from 30-40 years of age, able to give spiritual as well as professional help to her patients. We also need another sister. Both sisters must be fully qualified State-registered nurses and State-registered midwives; if the senior sister possessed a teaching diploma so much the better, but this is not essential. In both cases the hospital is prepared in the first instance to pay the sisters' fares to Durban (see also supplement LIII).

As it is now necessary for nurses intending to practise here to be registered with the South African Nursing Council, before entering the country the sisters should apply to the Council, P.O. Box 1123, Pretoria, South Africa. This registration takes some little time.

Umlazi Hospital has beds for about 200 children crippled by polio or tuberculosis; there is also a maternity ward of 21 beds. Last year we had 844 deliveries, and this work, together with the antenatal clinic, makes great demands upon our small staff. We have an outpatient department where last year we had a total attendance of 4,452.

We are writing this letter because our need is so desperate and we hope that you may be able to accord us the hospitality of your paper to make it known to your readers. Perhaps some nurse, who is now waiting for the next step in her professional career to be made plain, may read it and feel called to make further inquiries about one or other of these posts. In this happy event she should in the first instance apply to Dr. Veronica Thres, S.P.G. House, 15, Tufton Street, Westminster, S.W.1.

MARIA DU TOIT, M.B., CH.B., M.B.E., medical superintendent.
RICHARD BROOKE, Archdeacon of Durban and deputy chairman of the board of management.

Umlazi Mission Hospital,
Reunion, Natal.

AT THE THEATRE

Macbeth (*Old Vic*)

Though not perhaps the most notable of recent presentations, this production, directed by Douglas Seale, has a number of outstanding points. The three witches, who materialize from the awesome scenery, are real yet wraithlike and full of personality, but the other fantastic manifestations are not quite so successful. Michael Horden plays a thoughtful and disturbed Macbeth, goaded by desperation into horror, while Beatrix Lehmann, as Lady Macbeth, epitomizes the venom of ambition transformed into misery by failure. John Phillips plays Macduff and Edward Hardwicke makes Seyton, servant to Macbeth, into a most sinister accomplice. This is an interesting rather than a particularly memorable presentation but well worth a visit.

Solution to Christmas Crossword

Across. 1. Present day. 7. Apricot. 8. Games. 10. Coy. 11. Accidents. 13. Lights. 15. Lassie. 17. Overdraft. 18. Tea. 19. Tiffs. 21. Demonic. 22. Blancmange.

Down. 1. Party. 2. Enchanted. 3. Entice. 4. Tog. 6. Almonds. 6. Parcel post. 9. Sustenance. 12. Draftsman. 14. Gleeful. 16. Random. 18. Tinge. 20. Sin.

Prizewinners

First prize, £1 1s., to Miss Kunz, Belmont Hospital, Sutton, Surrey. Second prize, 10s. 6d., to Miss Elizabeth W. Gracey, 6, Eileen Gardens, Windsor Park, Belfast, N. Ireland.

Writing for the Nursing Press

How do you go about writing for the nursing press? It may be an account of a Branch meeting or a study day; you may be cajoled into writing a case history or you may even want to burst into print with a revolutionary idea that has just struck you! The usual advice to those who want to write is to buy a pencil and paper and go ahead. But this is hardly of much help to you.

A professional journal is not a parish magazine; readers in Ashby-de-la-Zouch are not really interested in the hall that was so kindly lent by permission of the matron and the hospital management for that winter fair in Wessex. One should be able to assume that these people have already been thanked for their generosity. Nor, unless you are possessed of the genius of Charles Lamb, should you mention that delicious tea; it takes a writer who can evoke the exact memory of roast pork to convince anyone else that food was in any way exceptional.

Tired Words

And remember, please, bouquets that are so charmingly offered to so-and-so who graciously consented to take the chair are out of place in print. So-and-so should have been properly thanked by a letter at the time. Try not to over-work words; they become stale with repetition. Unless you can show convincingly *how* a lecture provided 'food for thought' no one will really believe you. 'Momentous events', 'stimulating talk'—use a little judgement with such phrases. What would you say if there really was a momentous event?

So, when you've written your six pages of beautiful copy, go through it ruthlessly and reduce it to six lines; to be really accomplished you should then cut it down to six words. Then type it, using double spacing and leave a wide margin because the sub-editors may need to cut and amend it according to the space available. Don't forget to add your name and address.

Case Studies

Suppose you're writing a case study; please remember that the first essential of a sentence is that it must have a verb. Some case studies read like shopping lists—a catalogue of drugs followed by a terse phrase completed by initials. This is all very well when you're writing the night report, because the people reading it will know the patient. But if it is for publication you must conjure up the patient as an individual for the readers, who have never seen him and, unless you do your work well, never will. Many of the case studies published are excellent and after reading them one feels that the patient was nursed and treated imaginatively.

If you're going to write an article, then make up your mind before you begin what you want to say. Don't have a vague idea which you then wrap around in a cotton-wool wodge of words. In journalism no sentence should have to be read more than once. Express yourself simply, clearly and with a minimum of padding. It's up to you to persuade the reader to finish the article; editorial assistants who will see your manuscript first are paid to read it; readers aren't and—unless you interest them—they won't. Newspapers put all their punch, and often all their information, in their first paragraph, knowing full well that a number of readers will not bother to read beyond the first few lines. Magazine writing is not as condensed as this, but the opening paragraph is still extremely important.

Well-pruned Facts

The middle or body of your article should be clear, factual and devoid of abstractions. Your examples should be from your own experiences, which will be shared by many of your readers, the majority of whom are nurses. Prune your work regardless of your own feelings at losing that felicitous phrase—it is better to be under-dressed than over-dressed. Your final paragraph should be a summary or conclusion; don't leave the reader in the air; leave her feeling satisfied, thoughtful or provoked; don't just leave her.

Where are you going to market this manuscript, which by now has been rewritten several times? (The cart has really been put before the horse, because you should have chosen your market before you wrote your article.) You should have studied several issues of each of the nursing journals in this country and aimed your article carefully with the readership in mind. They are all different; one may be exclusively for one branch of the profession; another may publish critical and controversial material; a third may be unstinting in its praise of nurses. Compare the presentation of the same piece of news in more than one journal—is it presented critically from a nursing angle or is it presented without comment? Try to determine the editorial policy.

Copyright

Before you accept the offer the editor makes you, be quite clear as to what you are selling; this involves copyright. If the magazine buys the article outright, you surrender the copyright and have no further claim on it: you should expect more payment for this than for an article which is accepted only for first British rights. Then you can sell the article again, elsewhere, either in this country or overseas and your initial payment will be less.

Never offer the same article to more than one editor at a time; this will annoy the editors and may cause considerable confusion. Wait until you have a rejection slip before offering it elsewhere, but if it is rejected you should try to find out for yourself why it has failed to convince the editor of its worth.

So there you are; brevity and double spacing. There is no reason why any one of you shouldn't be able to write for publication and payment; no editor can have too much material to choose from and all editors welcome contributions. Every nurse has something to say that is of value. Why not say it?

BOOK REVIEWS

Light in the Night. *An S.C.M. Press Pocket Book.*

It is well known that 'religious' people are sometimes the worst patients in the sense that they grumble more about their ailments and sufferings than do those who profess no particular religious beliefs.

This little book, by a Wantage Sister, would be an excellent thing to put in the hands of those who know their way about the Bible, who are familiar with Christian hymnology and who don't know quite how to handle their sufferings positively.

More 'choosily', it could be put into the hands of those who profess no religion, as a gentle introduction to saying prayers, not only for themselves but also for other people—their doctors, their nurses, chaplain, fellow-patients and so on.

One doubts the wisdom of including at the end the hymn,

'Lord, it belongs not to my care
Whether I die or live . . .'

but the other prayers and suggested ejaculations are likely to be of tremendous help to those who are ill and in pain or distress.

K.C.

To the Anglican Nurse. *Church Information Board, 2½d. each, 20s. per 100, plus postage.*

In many training schools nurses who are just beginning their careers have lectures from the chaplain of their hospital about the different ways in which they may help him in his work. But this is not always possible.

In this pamphlet the matron of a London teaching hospital has described in an admirably concise fashion the chaplain's task as it affects the nurse and the nurse's own Christian responsibilities.

It is hoped that these will be made available by hospital authorities for their new nurses.

K.C.

Yes, Doctor . . .
from layettes
to rompers

Scott's Twin-Pack

keeps them growing

COMPOSITE ANALYSIS

OAT

Scott's Baby Cereal—Oat consists of oat flour, malt extract, bone phosphate, calcium carbonate, dried yeast, salt, iron and ammonium citrate, manganese sulphate, copper sulphate and calciferol (Vitamin D.)

	per cent
Fat (by acid hydrolysis)	6.2
Protein (N x 6.25)	11.2
Carbohydrate	72.3
Mineral Salts	2.4
Fibre	0.6
Moisture	7.3

	per oz.
Vitamin D	400 I.U.
Vitamin B_1 (as Aneurin Hydrochloride)	0.22 mg.

	grm. per oz.
Fat (by acid hydrolysis)	1.76
Protein (N x 6.25)	3.18
Carbohydrate	20.53

	mg. per oz.
Iron	6.0
Calcium	170.0
Phosphorus	110.0
Trace elements: Zinc	1.0
Trace elements: Copper	0.1
Trace elements: Manganese	1.0

Calories 114 per oz.

WHEAT

Scott's Baby Cereal—Wheat consists of wheat flour, malt extract, wheat germ, bone phosphate, calcium carbonate, dried yeast, salt, iron and ammonium citrate, manganese sulphate, copper sulphate and calciferol (Vitamin D.)

	per cent
Fat (by acid hydrolysis)	2.0
Protein (N x 6.25)	14.0
Carbohydrate	72.5
Mineral Salts	2.6
Fibre	0.4
Moisture	8.5

	per oz.
Vitamin D	400 I.U.
Vitamin B_1 (as Aneurin Hydrochloride)	0.17 mg.

	grm. per oz.
Fat (by acid hydrolysis)	0.57
Protein (N x 6.25)	3.98
Carbohydrate	20.59

	mg. per oz.
Iron	6.0
Calcium	170.0
Phosphorus	100.0
Trace elements: Zinc	0.5
Trace elements: Copper	0.1
Trace elements: Manganese	0.3

Calories 106 per oz.

PROFESSIONAL SAMPLES and explanatory leaflets, including diet sheets, are available on request.

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Royal College of Nursing

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BELFAST: 6, College Gardens

PUBLIC HEALTH SECTION

Liverpool. Carnegie Welfare Centre, Arrad Street, Liverpool, Monday, January 26, 6 p.m. Annual general meeting.

WARD AND DEPARTMENTAL SISTERS SECTION

Birmingham and Three Counties. St. Chad's Hospital, Hagley Road, Birmingham, Wednesday, January 28, 7 p.m. Annual general meeting.

BRANCHES

Birmingham and Three Counties. Children's Hospital, Birmingham, Thursday, February 12; Branch meeting. St. Chad's Hospital, Birmingham, Tuesday, March 3, annual general meeting. Details later.

Gloucester. Gloucester Royal Hospital, Great Western Road Branch, Monday, January 26, 6 p.m. Monthly business meeting.

Lanarkshire. Child Welfare Clinic, Stewarton Street, Wishaw, Thursday, January 29, 7 p.m. General meeting.

North Eastern Metropolitan. Moorfields Hospital, City Road, Wednesday, January 28, 7 p.m. General meeting; demonstration of light coagulator (for detached retina) by Mr. Fison. Old Street Station or trolley 641.

West Cumberland. Workington Infirmary, February 4, 7.15 p.m. Annual general meeting.

WARD SISTERS' COURSE
September-December 1958

Pass List—London

Ade-Onojobi, M. M.	Mamby, B. W.
Agyepong, E. G.	Marryshow, M.
Alleyne, E. C.	Ndwandwa, T. E. T.
Arde-Acquah, M. R.	Oba, G. H. C.
Atkins, P. W.	Obi, E. C. Y.[1], [2]
Awobokun, V. I. A.	Ojo, T. A.
Bankole, S. O.[1]	Osinloye, A. O.
Ben-Mazwi, F. R. N.	Rothschild, N.
Franklin, P. F.	Rouse, E. A.
Johnson, A. A. O.[2]	Soretire, A. A.
Lawson, V. O.	Thomas, O. O.
	Williams, M. T.

Pass List—Edinburgh

Burke, M. M. R. S.	Mills, M. H.
Cooper, D. M.	Mills, P. J.
Eaton, M. R.[2]	Murdoch, A. I. M.
Gyamarah, E. A.	Shaw, J. J.
	White, M. M. L.

[1] distinction in Ward Administration.
[2] distinction in Psychology in relation to Ward Administration.

ROYAL COLLEGE OF NURSING APPEAL
for the Nation's Fund for Nurses

Once again we have received a very generous donation from a group of nurses We send our grateful thanks to them and to all the other donors.

Contributions for January 9-16

	£	s.	d
Roxbourne Hospital, South Harrow. 'In memory of an ex-member of staff' ..	1	10	0
Miss Ligertwood		6	0
Miss H. B. Upperton	1	0	0
Miss A. Kitney	2	0	0
Mrs. C. A. Frier		10	0
Members of Mrs. Coward's Trained Nurses' Institute	47	6	0
Miss M. A. Henderson	1	0	0
College Member 81303	5	0	0

Total £58 12s.

E. F. INGLE,
Secretary, Royal College of Nursing Appeal for the Nation's Fund for Nurses, 1a, Henrietta Place, Cavendish Square, London, W.1.

ADDITIONS TO THE LIBRARY

Alexander, E. L. Care of the patient in surgery—including techniques. (St. Louis, Mosby, 1958.)
American Industrial Hygiene Association. Hygienic guides series. (Detroit, The Association.)
Bartlett, F. Thinking: an experimental and social study. (Allen and Unwin, 1958.)
British Medical Association. The medical practitioners' handbook. (British Medical Association, 1958.)
Brompton Hospital Reports. Vol. XXVI, 1957. (Lloyd Luke, 1958.)
Bullock, R. P. What do nurses think of their profession? (Columbia, Ohio. Ohio State University Research Foundation, 1954.)
Bunton, G. L. Fluid balance without tears, or the child's guide to electrolytes. (No imprint, 1957.)
Burdon, K. L. Textbook of microbiology. 4th edn. (New York, Macmillan, 1958.)
Bursk, E. C. ed. Human relations for management. (Constable, 1957.)
Caudill, W. The psychiatric hospital as a small community. (Cambridge, Mass., Harvard University Press, 1958.)
Douglas, J. W. B., and Blomfield, J. M. Children under five. (Allen and Unwin, 1958.)
General Register Office. The registrar-general's statistical review of England and Wales for the two years 1952-53. Supplement on mental health. (H.M.S.O., 1958.)†
Gillis, L. ed. Modern trends in surgical materials. (Butterworth, 1958.)
Harvey, B. M. R. Industrial health technology. (Butterworth, 1958.)
Hawkins, N. G. Medical sociology—theory, scope and methods. (Springfield, Illinois, Thomas, 1958.)
Hughes, E. and others. 20,000 nurses tell their story: a report on the American Nurses' Association Studies of Nursing Functions, by Everett Hughes and others. (Philadelphia, Lippincott, 1958.)
Institute of Hospital Administrators. Committees and communications. (The Institute, 1958.)†
ILO. Organization of Occupational Health Services in places of employment. Report of the 42nd and 43rd International Labour Conference sessions. (Geneva, ILO, 1958.)
James, J. D. Practical blood transfusion. (Oxford, Blackwell, 1958.)
Johnston, R. V. Personnel program guide for nursing education and nursing service agencies. (Philadelphia, Saunders, 1958.)
Kalkman, M. E. Introduction to psychiatric nursing, 2nd edn. (New York, McGraw-Hill, 1958.)
Karelitz, S. When your child is ill. (Cape, 1958.)
Klutas, E. M. Nursing supervision in industry. (National League for Nursing, 1958.)
Lambertson, E. Education for nursing leadership. (Philadelphia, Lippincott, 1958.)
Ling, T. M., and O'Malley, C. J. S. Rehabilitation after illness and accident. (Baillière, Tindall and Cox, 1958.)
McLean, A. A., and Taylor, G. C. Mental health in industry. (New York, McGraw-Hill, 1958.)
Marsh, D. C. Changing social structure of England and Wales, 1871-1951. (Routledge, Kegan Paul, 1958.)
Ministry of Health. Report, 1957. Part I. (*a*) The National Health Service. (*b*) Wel-

NURSES AND MIDWIVES WHITLEY COUNCIL

STAFF SIDE

MEETINGS OF COMMITTEES of the Staff Side were held on January 13.

Midwives Standing Committee

Pupil Midwives Training Allowances. It was reported that the Management Side had accepted a proposal that training allowances of nurses taking midwifery training should be increased. The new allowances would be:

	£
S.R.N. or R.S.C.N. (in Scotland R.G.N., R.S.C.N. or R.F.N.) ..	394
S.E.A.N. First period	368
Second period	378

The Management Side had not agreed that the allowances paid to pupil midwives who were not nurses should be increased.

Assistant Matrons in Maternity Hospitals (Training). It was reported that the Management Side had agreed to the introduction of a new salary scale to be applied to assistant matrons of maternity hospitals (training) of 100 beds and over; the new scale would be £679 × 21(6) × 5(1)—£810.

Salaries of Midwives. It was agreed that special consideration should be given to the salaries of midwives apart from the claim for a 5 per cent. increase at present under negotiation and proposals were agreed for submission to the Management Side.

Negotiating Committee and Management Side

On Tuesday, January 13, the Negotiating Committee met the Management Side to discuss the claim for an increase of 5 per cent. in all salaries and training allowances. The meeting was adjourned until January 27 when the negotiations will be resumed.

fare, food and drugs, civil defence. (H.M.S.O., 1958.)†

National Association for Mental Health. The residential care of disturbed children: being the proceedings of the 14th Inter-Clinic conference for staffs of child guidance clinics 1958. (The Association, 1958).†

National Old People's Welfare Council. The care of the elderly: report of the ninth national conference. (The Council, 1958.)†

North Regional Association for the Deaf. Deafness: a survey of the problems. (Manchester, The Association, 1958.)

Parliament. Local Government Act, 1958. (H.M.S.O., 1958.)†

Pirie, A. ed. Fall-out—radiation hazards from nuclear explosions. (McGibbon and Kee, 1958.)

Practitioner. Advances in treatment. (The Practitioner, October 1958.)

Renwick, E. D. Short history of the Order of St. John. (The Order of St. John, 1958.)

Robertson, J. Young children in hospital. (Tavistock Publications Ltd., 1958.)

Russell, W. R. The physiology of learning. (Edinburgh, The Royal College of Physicians, 1957.)†

Samuels, H. Industrial Law. 5th edn. (Pitman, 1958.)

Scotland, Department of Health and Scottish Health Services Council. Mental health legislation: report by a committee appointed by the Council. (H.M.S.O., 1958.)

Spaney, E., and Jennings, L. A. The art of studying—a guide for student nurses. (Philadelphia, Lippincott, 1958.)

Spencer, A. M. Nurses' textbook of anatomy and physiology. 2nd edn. (Faber, 1958.)

Stafford, E. S., and Diller, D. Surgery and surgical nursing. 3rd edn. (Philadelphia, Saunders, 1958.)

Titmuss, R. M. Essays on the Welfare State. (Allen and Unwin, 1958.)

Wain, H. The story behind the word: some interesting origins of medical terms. (Springfield, Illinois, Thomas, 1958.)[1]

World Health Organization. Publications of WHO, 1947-57—a bibliography. (Geneva, WHO, 1958.)

† Pamphlet. [1] Reference.

COMING EVENTS

King Edward's Hospital Fund for London.—Convalescent Homes Conference, Queen Elizabeth College, Campden Hill Road, London, W.8, April 10 and 11.

NASEAN, South-West London Branch.—General meeting, St. George's School of Nursing, 7, Knightsbridge, S.W.1, Wednesday, January 28, 8 p.m.

National Council of Nurses of Great Britain and Northern Ireland.—Westminster Hospital, S.W.1, Thursday, April 23, 2.15 p.m. Executive meeting.

Royal College of Midwives. Approved refresher course, Westcliff-on-Sea, February 8-14. Full details from Miss E. Snelling, education officer, R.C.M., 15, Mansfield Street, London, W.1.

Royal Society of Health. Papers on *Prevention of Four Epidemic Diseases*, Dr. John Sleigh, deputy medical officer of health, Newport, and *The Clean Air Act 1956—Practice and Problem*, Mr. R. G. Coslett, deputy chief public health inspector, Newport, at the Civic Centre, Newport, Wednesday, January 28, 10 a.m.

The Housing Centre Trust.—Annual conference on *Housing*, County Hall, Westminster, London, S.W.1, July 1, 2 and 3. Fees 30s. (non-members £3).

OBITUARY

Miss E. C. Davis

We regret to announce the death of Miss Ellen Catherine Davis on December 26. After training at the General Infirmary at Leeds and at the Nightingale Home, Derby, she held posts in Birmingham, Rugby, Preston, Cardiff and Stoke-on-Trent, before becoming matron of Moorgate General Hospital, Rotherham, Yorks, where she served for 24 years. Miss Davis was an examiner for the General Nursing Council for 25 years; she was a life member of the Royal College of Nursing.

Miss F. E. Welburn

We announce with regret the death, in a road accident, of Miss Florence Elizabeth Welburn, deputy matron at Leicester Royal Infirmary. Miss Welburn trained at Nottingham General Hospital, and was also a qualified midwife and State-registered fever nurse. She had held posts as night superintendent at the Royal Hospital, Wolverhampton, assistant matron at the Hospital for Women, Leeds, and assistant matron at Addenbrooke's Hospital, Cambridge. She took the course in nursing administration at the Royal College of Nursing before being appointed deputy matron at Leicester in 1957, and the following tribute comes from the Education Department at the College: "Miss Welburn was a student whose consistently high standards and imperturbable good humour are remembered with great appreciation. The atmosphere she created was a happy combination of serenity and cheerfulness. In her period of service as a nursing administrator she must already have made a most valued contribution, setting an example of integrity which will be a lasting influence. Her qualities certainly cannot well be spared from the hospital world today, and her loss is a sad one indeed for her friends and colleagues."

Television Programmes

B.B.C. Television . . . 'Seeing is Believing', in *Eye on Research* on January 27, demonstrates the use of the microscope in research today. *Lifeline*, on Thursday, January 29, deals with leucotomy; the consultant psychiatrist will have with him in the studio a neurosurgeon and some patients who have undergone this operation. Children's programmes, on Friday, January 30, include *Variety for Deaf Children;* Stephen Skoyles draws the pictures.

APPOINTMENTS

Oulton Hall and Associated Hospitals, near Leeds

MRS. KATHLEEN I. HARVEY, R.M.N., R.M.P.A., has been appointed matron from March 1. Mrs. Harvey took her mental nursing training at Netherne Hospital, Coulsdon, Surrey, where she later became staff nurse and ward sister. She was assistant matron at St. Mary's Hospital, Kettering, and at the Central Hospital, Royal Western Counties Institution, Starcross, Devon; she is at present deputy matron, Chelmsley Hospital, Marston Green, Birmingham.

Halifax General Hospital

MISS JANET E. TYRER, S.R.N., S.C.M., R.F.N., S.T.DIP., D.N., has been appointed matron from February 1. Miss Tyrer trained at St. Giles' Hospital, Camberwell, and Charing Cross Hospital where she obtained her housekeeping certificate; she also took the Nursing Administration (Hospital) Certificate at the Royal College of Nursing. She served as a sister in the Territorial Army Nursing Service, as sister tutor at Monsall Hospital, Manchester, and as assistant matron at Salford and at Newmarket General Hospital. She was subsequently appointed deputy matron at Crumpsall Hospital, Manchester.

LOUISE MARGARET MATERNITY HOSPITAL, ALDERSHOT

Brigadier Dame Monica Johnson, matron - in - chief and director of Army Nursing Services, with Major H. M. Grant, matron of the hospital, during her visit last week to the hospital and the preliminary training school of the QARANC.

Here and There

Dynamic Health Education

The study theme for the Central Council for Health Education summer school, 1959, will be *The Dynamic Approach to Health Education*. The school will be held at Neuadd Reichel, University College of North Wales, Bangor, from August 18 to 28.

Among the lecturers and group leaders will be Professor Fraser Brockington, professor of social and preventive medicine, University of Manchester; Dr. J. L. Burn, medical officer of health, Salford; Miss Ellen Broe, director, Florence Nightingale Education Division, ICN, and Miss R. Hale, principal tutor, Health Visitors' Course, Battersea College of Technology.

Applications should be made to the Medical Director, CCHE, Tavistock House North, Tavistock Square, London, W.C.1. The inclusive fee will be £22.

Slough Industrial Health Service

A film has been made of the Slough Industrial Health Service which describes all the facilities of the service including Farnham Park Rehabilitation Centre and the facilities provided by the Occupational Hygiene Laboratories. The 16 mm. Kodachrome Optical Track sound film runs for 25 minutes and is available on loan, free of charge apart from postage, from Slough Industrial Health Service, Headquarters, Community Centre, Farnham Road, Slough.

Mother Mary Augustine Aikenhead

Towards the end of last year the Republic of Ireland issued two stamps, a 3d. and a 1s. 3d. portraying Mother Mary Augustine Aikenhead, who died 100 years ago on October 20, 1858. The daughter of a Cork physician, Mary Aikenhead was persuaded to found the Irish Sisters of Charity in 1812; she trained at a convent in York. The Irish Sisters began their activities at Dublin in 1815, visiting the poor in the meanest quarters of the city and performing nursing duties during epidemics of typhus and cholera. Though an invalid for many years, confined to bed with spinal disease, the Reverend Mother in 1834 founded St. Vincent's Hospital, Dublin.

Japanese Red Cross

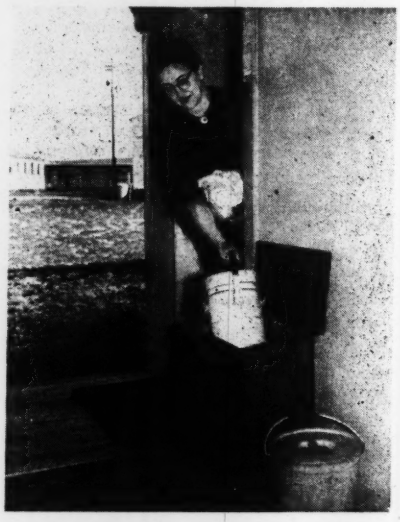
Miss Kimiko Kishii of Japan who took a special course in administration arranged by the Royal College of Nursing during the 1955/6 session, was appointed director, Nursing Services of the Japanese Red Cross Society in Tokyo in September 1958, in succession to Miss Hayashi who has retired.

Care of Premature Babies

Dr. Neville Butler gave the fourth Sir William Power Memorial Lecture at the Royal College of Midwives on January 14, on 'The Care and Fate of the Premature Baby'. His controversial and at times delightfully amusing remarks led the audience of about 100 to think again about present practices.

In particular, Dr. Butler stressed the vital importance of not overheating, but rather allowing the infant to regulate its own body temperature; also the need to measure frequently the oxygen concentration in order to keep it at a minimum.

He also pointed out that the very small infant under 5 lb. in weight born near term was more likely later on to be mentally retarded than the premature baby who up to the time of its birth had received full nourishment from the placenta which in the former had been deficient for some time before delivery.



COLD RESEARCH VOLUNTEER collects her dinner from a container outside her hut at the Common Cold Research Unit at the Harvard Hospital near Salisbury. The unit is appealing for volunteers to act as guinea pigs.

Central Council for Health Education

The inaugural address for the health education seminar for medical officers of health to be held in London from February 24-27 will be given by Dr. W. P. D. Logan, medical statistician, General Register Office.

The British Tuberculosis Association

The B.T.A. badge is available for holders of the British Tuberculosis Association Certificate in Nursing; nurses who have obtained the Association's certificate since the inception of the examination are entitled to apply for the badge, price 5s. post free. Applicants should state: training centre, date when Part 2 of the examination was passed, maiden name in the case of women who have married since obtaining the certificate, and index number if registered since July 1954.

Apply to Mr. L. D. Booker, administrative secretary, 59, Portland Place, London, W.1. Certificates should *not* be sent with the application as the Association cannot be held responsible for their loss.

Visit to R.A.F. Overseas

The matron-in-chief of Princess Mary's Royal Air Force Nursing Service, Air Commandant Dame Alice Mary Williamson, left on January 21 for Singapore on a six-week tour of R.A.F. medical establishments in the Far East and Middle East.

Dame Alice Mary will be accompanied as far as Singapore by the matron-in-chief and director of Army Nursing Services, Brigadier Dame Monica Johnson—both wish to obtain first-hand experience of the arrangements for patients flown home in Comet 2 aircraft of Transport Command.

Air Commandant Williamson will visit R.A.F. medical establishments in Singapore, Hong Kong, Ceylon, Bahrain and Aden.

Camelon Hospital, Scotland

Camelon Hospital, used recently for the care of old people, is to close and patients will be transferred to Falkirk and District Royal Infirmary. This decision by the Western Regional Board has been accepted by the Stirlingshire Public Health Committee which may take over Camelon.

QARANC Honours

The following received the A.R.R.C.: MAJOR CHRISTINA MOSELEY, Q.A.R.A.N.C. who trained at St. Bartholomew's Hospital, London, and took midwifery at Queen Charlotte's Hospital, London. She joined the Army nursing service in 1942 and served in North Africa, and in India from 1945-47. Major Moseley took the health visitors' course at the Royal College of Nursing in 1951 and is now serving in Gibraltar. MAJOR R. V. HEPBURN, Q.A.R.A.N.C., who trained at Edinburgh Royal Infirmary, and took her midwifery training at the Simpson Royal Maternity Pavilion, Edinburgh. She is at present serving at Hostert, Germany.

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PACKINGS: Hand Cream in 1 oz. tube (2/5) 4 oz. jar (7/3.) Where a less greasy product is required, the lotion is recommended; available in 2 oz. (2/5) and 4 oz. (3/5) bottles.

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